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O'Shea, DO  
*Immediate  
Past President*

**ANNUAL MEETING**  
**Manchester Grand Hyatt ▪ San Diego, CA**  
**April 29, 2016 ▪ 6:00-8:00 AM - Cortez Hill AB**

**BUSINESS MEETING AGENDA**

Anna Hayden, DO, President, Presiding

	<b>TAB</b>
I. Call to Order/Approval of Agenda	
II. Approval of January 8, 2016 Minutes - Action Item	<b>1</b>
III. NBOME Update – Gary Slick, DO/John Gimpel, DO/Sandra Waters	
IV. Update on Communications to State Boards Re: Single GME Accreditation	<b>2</b>
<b>(AAOE Fellows Only)</b>	
V. FSMB Annual Meeting	
a. Resolutions	<b>3</b>
b. Elections	<b>4</b>
VI. Osteopathic Medical Regulation/Licensure Roundtable	<b>5</b>
VII. Announcements	

**Future Meeting Dates**

AAOE Business Meeting—July 2016 (AOA Annual Business Meeting)  
AAOE Summit—January 2017 (AOA OMEL Meeting)



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Shaffer, DO  
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Past President*

**BUSINESS MEETING**

**MANCHESTER GRAND HYATT ■ SAN DIEGO, CA**

**April 29, 2016**

List of Attendees

- Bridget Bellingar, DO - Florida Board of Osteopathic Medicine
- Boyd Buser, DO - Kentucky Board of Medical Licensure
- Humanya Chaudhry, DO – President & CEO, Federation of State Medical Boards
- Jeremy Edmonds, DO – New Mexico Board of Osteopathic Medical Examiners
- Jone Geimer-Flanders, DO - Hawaii Medical Board
- Randel Gibson, DO - Vice President, Kentucky Board of Medical Licensure
- John Gimpel, DO, President & CEO, National Board of Osteopathic Medical Examiners
- James F. Griffin, DO – Rhode Island Board of Medical Licensure and Discipline
- Eric R. Groce, DO – Colorado Medical Board
- Anna Hayden, DO –President, AAOE
- Ernest Miller, DO –Vice President, AAOE
- John Peterson, DO - Vermont Board of Osteopathic Physicians & Surgeons
- Wayne Reynolds, DO – President, Virginia Board of Medicine
- David Rydell, DO - Maine Board of Osteopathic Licensure
- Nicholas A. Schilligo, MS – Associate Vice President, AOA State Government Affairs
- George Scott, DO – New Jersey State Board of Medical Examiners
- Gary Slick, DO – Chair, National Board of Osteopathic Medical Examiners
- Anita Steinbergh, DO – President, State Medical Board of Ohio
- Scott Steingard, DO – President, Arizona Board of Osteopathic Examiners in Medicine and Surgery
- Barbara Walker, DO Secretary-Treasurer, AAOE
- Sandra Waters, MEM – Vice President, Collaborative Initiatives, National Board of Osteopathic Medical Examiners
- Joseph Willett, DO – Minnesota Board of Medical Practice
- Joseph A. Zummato, DO – President, Osteopathic Medical Board California

142 E. Ontario  
Chicago, IL  
60611

[www.aaoe-net.org](http://www.aaoe-net.org)

312-202-8185  
312-202-8485 fax



## BUSINESS MEETING MINUTES

Friday, January 8, 2016  
San Xavier Room – La Cantera Hill Country Resort - San Antonio, TX  
10:45 AM – 12:30 PM

### **Fellows Present:**

Anna Hayden, DO, President, AAOE; Florida Board of Osteopathic Medicine  
Boyd Buser, DO, Kentucky Board of Medical Licensure  
James DiRenna, DO, Missouri State Board of Registration for the Healing Arts  
Randel Gibson, DO, Kentucky Board of Medical Licensure  
James Griffin, DO, Rhode Island Board of Medical Licensure and Discipline  
James Lally, DO, Osteopathic Medical Board of California  
Lynn Mark, DO, New York State Board for Medicine  
Michelle Mendez, DO, Florida Board of Osteopathic Medicine  
Ernest Miller Jr., DO, Vice President, AAOE; West Virginia Board of Osteopathic Medicine  
Geraldine O'Shea, DO, Immediate Past President, AAOE  
Wayne Reynolds, DO, Virginia Board of Medicine  
Dana Shaffer, DO, Kentucky Board of Medical Licensure  
David Tannehill, DO, Missouri State Board of Registration for the Healing Arts  
Frank Tursi, DO, Pennsylvania State Board of Osteopathic Medicine  
Barbara E. Walker, DO, Secretary-Treasurer, AAOE; North Carolina Medical Board  
Michael Wieting, DO, Tennessee Board of Osteopathic Examiners  
Joseph Zammuto, DO, California Osteopathic Medical Board

### **Non-Members/Observers Present:**

Humayun Chaudhry, DO, President and CEO, Federation of State Medical Boards  
John Gimpel, DO, President and CEO, National Board of Osteopathic Medical Examiners  
Gary Slick, DO, Chair, National Board of Osteopathic Medical Examiners

### **AOA Leaders/Staff:**

Ray Quintero, Senior Vice President, Public Affairs  
Nicholas A. Schilligo, MS, Associate Vice President, State Government Affairs

- I. AAOE President Anna Hayden, DO called the Business Meeting to order at 11:00 AM.
- II. Dr. Hayden presented the proposed agenda. James Griffin, DO made a motion to adopt the agenda; seconded by Geraldine O'Shea, DO. The motion unanimously adopted.  
  
Dr. Hayden invited Gary Slick, DO and John Gimpel, DO to provide an update on the activities of the National Board of Osteopathic Medical Examiners (NBOME). Dr. Slick/Dr. Gimpel discussed new initiatives embarked upon by the NBOME. Dr. Gimpel also mentioned

the need for the AAOE to nominate individuals to fill an upcoming vacancy of the NBOME Board of Directors.

- III. Dr. Hayden asked Humayun Chaudhry, DO to provide an update on the activities of the Federation of State Medical Boards (FSMB). Dr. Chaudhry discussed the progress of the Interstate Medical Licensure Compact and the states in which the Compact is gaining legislative momentum.
- IV. Dr. Hayden presented the draft minutes from the October 19, 2015 AAOE Business Meeting for approval. There was discussion regarding the additional information suggested by Mary Jo Capodice, DO prior to the meeting. The edit was made and the revised draft minutes were posted to the web site.  
  
Dr. Hayden asked for a motion to approve the revised draft minutes. Dr. O'Shea made a motion to approve the revised minutes; seconded by James DiRenna, DO and approved unanimously.
- V. Dr. Hayden asked Nicholas Schilligo to report on the ongoing activities of the AAOE. Mr. Schilligo provided a brief overview of administrative activities. He also provided an update on state government affairs issues of relevance to the AAOE. This included the interstate medical licensure compact, assistant physician and scope of practice.
- VI. Dr. Hayden led a roundtable open discussion regarding the issues impacting osteopathic medical regulation and licensure.
- VII. Dr. Hayden discussed the upcoming 2016 FSMB's elections, committee nominations and appointments, resolutions, Annual Meeting and related activities.
- VIII. Dr. Hayden provided the AAOE's future meeting dates, AAOE Annual Meeting (at FSMB Meeting) on April 29, 2016 in San Diego, CA and AAOE Business Meeting during OMED the week of September 16-20, 2016 in Anaheim, CA.
- IX. It was discussed and decided that Dr. Hayden would represent the AAOE at the International Association of Medical Regulatory Authorities (IAMRA) on September 20-23, 2016 in Melbourne, Australia.
- X. Dr. Hayden asked for any new business items or announcements. There being no further business, she asked for a motion to adjourn. Mark Lynn, DO made a motion to adjourn, seconded by James Lally, DO. Dr. Hayden adjourned the meeting at 12:30 PM.



AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St., Chicago, IL 60611-2864 ph (312) 202-8000 | (800) 621-1773 | [www.osteopathic.org](http://www.osteopathic.org)

March 9, 2016

Pennsylvania State Board of Osteopathic Medicine  
Aaron Hollinger, Administrator  
P.O. Box 2649  
Harrisburg, PA 17105-2649

Dear Mr. Hollinger:

In July 2015, the American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine and Accreditation Council for Graduate Medical Education (ACGME) began a five-year transition into a single accreditation system for graduate medical education (GME) in the United States. This new system, which will be fully implemented in July 2020, will allow graduates of osteopathic (DO) and allopathic (MD) medical schools to complete their postgraduate residency training in ACGME-accredited programs.

The new single GME accreditation system will allow participants to demonstrate achievement of common milestones and competencies. Postgraduate training in the unique principles and practice of the osteopathic medical profession will continue to exist through programs that receive osteopathic recognition by ACGME. In fact, MD medical school graduates will now be able to participate in residency training programs with osteopathic recognition. The AOA understands that an AOA-approved first year of postdoctoral training is required for osteopathic physician licensure in Pennsylvania. Once the transition to the single GME accreditation system is complete, the AOA will cease approval of training programs and there will no longer be training formally approved by the AOA. The AOA Board of Trustees recognizes successful completion of an “osteopathic-recognized” position in an ACGME-accredited training program as satisfying the AOA approved PGY-1 requirement for state licensure purposes, and requests that the Board adopt a similar policy to ensure that qualified DOs remain eligible for licensure under the single GME accreditation system.

In the new single GME accreditation system, training programs may apply to the ACGME’s Osteopathic Principles Committee for “Osteopathic Recognition.” The requirements for recognition are found on the ACGME website. The programs will train according to the recognition standards and will have specific osteopathic milestones with which to evaluate the maturation of physicians in osteopathic training.

We would also like to use this opportunity to provide some additional information about the transition toward single GME accreditation:

- The COMLEX-USA examination series remains the only tool available to assess osteopathic medical knowledge and demonstrate competency in the clinical skills needed to obtain a state medical license.
- The AOA will continue to offer board certification for physicians (DO and MD) who complete osteopathic-focused training, and are interested in incorporating osteopathic principles into their practice.
- Colleges of Osteopathic Medicine will continue to be accredited by the AOA Commission on Osteopathic College Accreditation.

The AOA is more than willing to act as a resource to the Board as the transition to a single GME accreditation system moves forward. If you have any questions about single GME accreditation, osteopathic education or AOA

board certification, please contact Nicholas A. Schilligo, MS, Associate Vice President of State Government Affairs, at (312)202-8185 or [nschilligo@osteopathic.org](mailto:nschilligo@osteopathic.org).

Sincerely,

A handwritten signature in black ink that reads "John H. Becher, DO". The signature is written in a cursive style with a loop at the end.

John Becher, DO  
President

enclosure

DRAFT

SUBJECT: AOA APPROVAL OF OGME-1 TRAINING

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: AOA Board of Trustees

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1 WHEREAS, the American Osteopathic Association (AOA), Accreditation Council for  
2 Graduate Medical Education (ACGME) and the American Association of Colleges of  
3 Osteopathic Medicine (AACOM) have agreed to pursue a single accreditation system;  
4 and

5 WHEREAS, as of June 30, 2020, graduate medical education training programs will be  
6 accredited by the ACGME and the AOA will cease accreditation activities; now,  
7 therefore, be it

8 RESOLVED, ~~that the AOA recognizes the Accreditation Council for Graduate Medical~~  
9 ~~Education (ACGME) PGY-1 as meeting the training requirements of AOA OGME-1~~  
10 **THAT AN OSTEOPATHIC PHYSICIAN WHO SUCCESSFULLY**  
11 **COMPLETES AN OSTEOPATHIC-FOCUSED TRACK IN AN ACGME**  
12 **ACCREDITED PGY-1 PROGRAM THAT HAS RECEIVED**  
13 **OSTEOPATHIC RECOGNITION WILL BE DEEMED TO HAVE**  
14 **COMPLETED AN AOA APPROVED PGY-1 FOR THE PURPOSES OF**  
15 **SATISFYING STATE LICENSURE REQUIREMENTS.**

Explanatory Statement:

The resolution was approved by electronic ballot. In a subsequent conference call discussion (without a quorum present), the following additional clarification was suggested:

This resolution is intended to proactively address only osteopathic training programs which seek ACGME accreditation from July 1, 2015 through June 30, 2020. The intent is to protect osteopathic interns and residents from problems obtaining state licensure as a result of the single accreditation system, and is not to retroactively approve training completed prior to the start of the single accreditation system.

The Bureau of Osteopathic Education (BOE) encourages that the AOA review all state statutes regarding osteopathic physician licensure so that other potential concerns relating to the single accreditation system can be addressed.

The BOE intends to further discuss licensure concerns at its upcoming meeting in May 2015.

**Resolution B-6 – M/2015 was Postponed definitely – 2015 BOT annual meeting (July 2015), Feb. 26, 2015 at the 2015 Midyear Meeting of the AOA Board of Trustees.**

BOT Reference Committee Explanatory Statement: DO trainees who complete an ACGME program can also seek approval through Resolution 42.

ACTION TAKEN APPROVED AS AMENDED

DATE July 16, 2015

**FEDERATION OF STATE MEDICAL BOARDS  
OF THE UNITED STATES, INC.**

**HOUSE OF DELEGATES ANNUAL BUSINESS MEETING  
SAN DIEGO, CALIFORNIA  
APRIL 30, 2016**

<b>Agenda Item</b>	<b>Tab</b>
1. Call to Order, 2:00 pm <i>J. Daniel Gifford, MD, FACP, Chair</i>	
2. Roll Call of Member Boards <i>Humayun J. Chaudhry, DO, MACP, President/CEO</i>	
3. Approval of Agenda <i>J. Daniel Gifford, MD, FACP, Chair</i>	
4. Introduction of Parliamentarian and Tellers <i>J. Daniel Gifford, MD, FACP, Chair</i>	
5. Welcome New Fellows, Courtesy Members, Affiliate Members and Official Observers <i>Humayun J. Chaudhry, DO, MACP, President/CEO</i>	
6. <a href="#"><u>Approval of Minutes of April 2015 Business Meeting</u></a> <i>J. Daniel Gifford, MD, FACP, Chair</i>	<a href="#"><u>A</u></a>
7. <a href="#"><u>Report of the Rules Committee</u></a> <i>Arthur S. Hengerer, MD, FACS, Chair-elect</i>	<a href="#"><u>B</u></a>
8. <a href="#"><u>Chair's Report of the Board of Directors</u></a> <i>J. Daniel Gifford, MD, FACP, Chair</i>	<a href="#"><u>C</u></a>
9. <a href="#"><u>Report of the President-CEO</u></a> <i>Humayun J. Chaudhry, DO, MACP, President/CEO</i>	<a href="#"><u>D</u></a>
10 <a href="#"><u>Report on the FSMB 2015-2020 Strategic Plan</u></a> <i>Humayun J. Chaudhry, DO, MACP, President/CEO</i>	<a href="#"><u>E</u></a>
11. <a href="#"><u>Treasurer's Report</u></a> <i>Ralph C. Loomis, MD, Treasurer</i>	<a href="#"><u>F</u></a>

12. [Report of Reference Committee A](#) G  
*H. Joseph Falgout, MD, Chair*
13. [Report of Reference Committee B](#) H  
*Marilyn J. Heine, MD, FACP, Chair*
14. [Report of the Nominating Committee](#) I  
*Donald H. Polk, DO, Immediate Past Chair*
15. Elections  
*J. Daniel Gifford, MD, FACP, Chair*
16. Reports of Representatives to Other Organizations (*written reports only*)
- a. [Accreditation Council For Continuing Medical Education](#) J  
*Linda Gage-White, MD, PhD & Michael D. Zanolli, MD*
- b. [Accreditation Council for Graduate Medical Education](#) K  
*Martin Crane, MD*
- c. [American Board of Medical Specialties](#) L  
*Jon V. Thomas, MD, MBA*
- d. [Educational Commission for Foreign Medical Graduates](#) M  
*Pamela Blizzard, MBA & Ram R. Krishna, MD*
- e. [National Board of Medical Examiners](#) N  
*Freda M. Bush, MD*  
*Arthur S. Hengerer, MD*  
*Barbara S. Schneidman, MD*  
*Lance A. Talmage, MD*  
*Jon V. Thomas, MD, MBA*
- f. [National Commission on Certification of Physician Assistants](#) O  
*Peggy R. Robinson, MS, MHS, PA-C*
17. Announcement of 2017-2019 Annual Meeting Sites  
*Humayun J. Chaudhry, DO, MACP, President/CEO*
18. Adjournment
- [Appendix I – House of Delegates Meeting Guidebook](#) P
- [Appendix II – FSMB Bylaws](#) Q

## **TAB G: Report of Reference Committee A**

### **MANAGEMENT NOTE:**

The following resolutions and reports will be submitted to Reference Committee A:

1. [Report of the Bylaws Committee](#)
2. [Resolution 16-2](#): Advocacy Efforts in Response to Antitrust Concerns of State Medical Boards (WY)
3. [BRD RPT 16-2](#): Report of the FSMB Workgroup on Marijuana and Medical Regulation
4. [Resolution 16-3](#): Physicians' Use of Marijuana (BOD)
5. [BRD RPT 16-3](#): Report of the FSMB Workgroup on Telemedicine Consultations



42 ARTICLE III. Officers: Election and Duties

43 Section B. Election of Officers

- 44
- 45 1. The Chair-elect shall ascend to the position of Chair at the Annual Meeting following the
  - 46 meeting in which the Chair-elect was elected.
  - 47 2. The Chair-elect shall be elected at each Annual Meeting of the House of Delegates.
  - 48 3. The Treasurer shall be elected every third year at the Annual Meeting of the House of
  - 49 Delegates.
  - 50 4. Officers shall be elected by a majority of the members of the House of Delegates present
  - 51 and voting.
  - 52 5. In any election, should no candidate receive a majority of the votes cast, a runoff election
  - 53 shall be held between the two candidates who receive the most votes for that office on the
  - 54 first ballot. **Up to two additional runoff elections shall be held.**
  - 55 **6. Prior to each election, the presiding officer shall cast a sealed vote that shall be**
  - 56 **counted only to resolve a tie that cannot be decided by the process set forth in this**
  - 57 **section.**

58

59 ARTICLE IV. Board of Directors

60 Section C. ~~Elections~~ **Election of Directors-at-Large**

- 61
- 62 1. At least three of the Directors-at-Large shall be elected each year at the Annual Meeting
  - 63 of the House of Delegates by a majority of the votes cast.
  - 64 2. If no candidate receives a majority of the votes on the first ballot, and one seat is to be
  - 65 filled, a runoff election shall be held between the two candidates who received the most
  - 66 votes on the first ballot.
  - 67 3. If more than one seat is to be filled from a single list of candidates, and if one or more
  - 68 seats are not filled by majority vote on the first ballot, a runoff election shall be held, with
  - 69 the ballot listing candidates equal in number to twice the number of ~~undesignated~~
  - 70 remaining to be filled. These candidates shall be those **remaining** who received the most
  - 71 votes ~~short of majority~~ on the first ballot. The same procedure shall be used for any
  - 72 required subsequent runoff elections. **In the event of a tie vote in a runoff election up**
  - 73 **to two additional runoff elections shall be held.**
  - 74 **4. Prior to the election, the presiding officer shall cast a sealed vote, ranking each**
  - 75 **candidate in a list. The presiding officer's vote is counted for the candidate in the**
  - 76 **runoff election who is highest on the list. The presiding officer's vote is counted only**
  - 77 **to resolve a tie that cannot be decided by the process set forth in this section.**
  - 78 **45.** Directors shall assume office upon final adjournment of the Annual Meeting of the House
  - 79 of Delegates at which they were elected.
  - 80 **56.** Only an individual who is a Fellow at the time of the individual's election shall be
  - 81 eligible for election as a Director of the FSMB.

83 ARTICLE VIII. Standing and Special Committees

84 Section H. Nominating Committee: Process for Election

- 85
- 86 1. The Nominating Committee shall be composed of seven individuals, six Fellows and the
- 87 Immediate Past Chair, who shall chair the Committee and serve without vote except in
- 88 the event of a tie.
- 89 2. At least three Fellows shall be elected at each Annual Meeting of the House of Delegates
- 90 by a plurality of votes cast, each to serve for a term of two years. **In the event of a tie**
- 91 **vote in a runoff election up to two additional runoff elections shall be held.**
- 92 **3. Prior to the election, the presiding officer shall cast a sealed vote, ranking each**
- 93 **candidate in a list. The presiding officer's vote is counted for the candidate in the**
- 94 **runoff election who is highest on the list. The presiding officer's vote is counted only**
- 95 **to resolve a tie that cannot be decided by the process set forth in this section.**
- 96 4. A member of the Nominating Committee may not serve consecutive terms. At least one
- 97 elected member of the Nominating Committee shall be a non-physician. With the
- 98 exception of the Immediate Past Chair, no two Committee members shall be from the
- 99 same member board and no officer or member of the Board of Directors shall serve on
- 100 the Committee.
- 101 ~~35.~~ Members of the Nominating Committee are not eligible for nomination by the
- 102 Committee.
- 103 ~~26.~~ Only an individual who is a Fellow at the time of the individual's election shall be
- 104 eligible for election as a member of the Nominating Committee.

Federation of State Medical Boards  
House of Delegates Meeting  
April 30, 2016

Subject: Advocacy Efforts in Response to Antitrust Concerns of State Medical Boards

Introduced by: Wyoming Board of Medicine

Approved: February 2016

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**Whereas,** Pursuant to the powers reserved to the states by the Tenth Amendment of the United States Constitution, regulatory decisions of the medical profession have historically been made by state medical boards based on informed judgments that balance multiple values held by the citizens of their state including, but not limited to, protecting patients from harmful or deceptive practices, ensuring a high quality of care, increasing access to care, and the promotion of a robust healthcare marketplace; and

**Whereas,** The United States Supreme Court's decision in *North Carolina State Board of Dental Examiners (NCSBDE) v. Federal Trade Commission (FTC)*, 135 S. Ct. 1101, rejected the historical application of state action immunity doctrine, which immunized the actions of state regulatory boards under federal antitrust law, and held that to receive such immunity, the actions of state regulatory boards must be consistent with a clearly articulated policy of the state and must be subject to active supervision by the state; and

**Whereas,** The Sherman Antitrust Act and related laws were passed by Congress to govern private business conduct within competitive markets and ensure the efficient operation of those markets, and were not intended by Congress to apply, nor have they previously been applied, to the role of state regulatory boards; and

**Whereas,** The United States Supreme Court's decision in *NCSBDE v. FTC* did not articulate the extent of supervision by the state necessary for a state regulatory board to be considered 'actively supervised;' and

**Whereas,** In October 2015, the FTC released *FTC Staff Guidance on Active Supervision of State Regulatory Boards Controlled by Market Participants*, which, in an attempt to provide clarity for state regulators, broadens the Supreme Court decision, proposing an expansive definition of active market participant and whether a board consists of a controlling number of active market participants; and

**Whereas,** The *FTC Staff Guidance on Active Supervision of State Regulatory Boards Controlled by Market Participants* called for imposition of additional levels of

state review, which will ultimately slow the regulatory process down and will be to the detriment of patients whom the Boards are seeking to protect; and

**Whereas,** In the wake of the decision in *NCSBDE v. FTC* and *FTC Staff Guidance on Active Supervision of State Regulatory Boards Controlled by Market Participants*, numerous antitrust lawsuits have been filed against a wide range of state professional licensing boards, including medical boards, nursing boards, and pharmacy boards, which threaten to create legal uncertainties that weaken the ability of state regulatory boards to protect the health and welfare of the public; and

**Whereas,** There is growing concern among state medical boards that the Supreme Court decision and the Federal Trade Commission guidance will prompt state and federal officials, in the name of preserving market competition, to institute changes that will restrain state medical boards from acting on behalf of public safety and reduce effectiveness and organizational efficiency;

Therefore, be it hereby

**Resolved,** That the Federation of State Medical Boards (FSMB) will advocate against the expanded application of antitrust principles which may compromise patient safety; and be it further

**Resolved,** That the FSMB will coordinate with state medical boards to develop appropriate responses to the application of antitrust principles at both the state and federal policy level, including, but not limited to, statutory or legislative amendment, development of model policies, and education of state government officials regarding the practical effects of the *NCSBDE v. FTC* decision on medical regulation; and be it further

**Resolved,** That the FSMB will advocate for federal legislative action to clarify that it is the intent of Congress that the state action immunity doctrine apply to health care licensing boards as it did prior to the issuance of the *NCSBDE v. FTC* decision; and be it further

**Resolved,** That the FSMB will continue to support, upon request, those state medical boards facing litigation alleging antitrust violations through the submission of amicus briefs and other supportive filings.

## REPORT OF THE BOARD OF DIRECTORS

**Subject: Report of the FSMB Workgroup on Marijuana and Medical Regulation**

**Referred to: Reference Committee A**

---

J. Daniel Gifford, MD, FACP, FSMB Chair, appointed the FSMB Workgroup on Marijuana and Medical Regulation in April 2015 to 1) guide the development of model policy guidelines regarding the use of medical marijuana in patient care, including conditions, diseases, or indications for which medical marijuana may be recommended; and, 2) develop a position statement or white paper regarding the regulation of licensees who use marijuana recreationally.

Members of the Workgroup were Gregory B. Snyder, MD, DABR, Chair; Eustaquio O. Abay, II, MD; Eric R. Groce, DO; Ronald D. Hedger, DO; Kimberly Kirchmeyer; Howard R. Krauss, MD; Micah Matthews, MPA; James V. McDonald, MD, MPH; and, Marc E. Rankin, MD. Participating ex officio were J. Daniel Gifford, MD, FACP; Arthur S. Hengerer, MD, FACS; and Humayun J. Chaudhry, DO, MACP.

The Workgroup met by web conference in July 2015 and in Washington, D.C. on November 2, 2015 to draft its report, *Model Guidelines for the Recommendation of Marijuana in Patient Care*. In completing its charge, the Workgroup reviewed relevant laws, rules, and board policies, as well as research reports, peer-reviewed articles, and policy statements from health-related professional organizations. In addition, a survey of FSMB member boards was conducted to determine their policy priority issues. A favorable response rate of 72.9% supported development of resources in the area of marijuana, including 1) recreational use by physicians (31.4%); 2) use by physicians for medical purposes (47.1%); and 3) the development of model guidelines for recommending marijuana for medical purposes to patients (49.0%).

The draft report was distributed to state medical and osteopathic boards for comment in December 2015. Comments were considered and the report was finalized and submitted to the FSMB Board of Directors for approval in February 2016.

The Board of Directors has approved the *Model Guidelines for the Recommendation of Marijuana in Patient Care (Attachment 1)* and recommends its adoption by the House of Delegates. These model guidelines are provided as a resource to boards in states that have legalized, or are considering legalizing, marijuana for medical purposes. The document may also be a valuable tool in educating physicians and other health professionals under the jurisdiction of the board about appropriate standards for professional and ethical conduct when considering recommending marijuana as part of patient care.

### **ITEM FOR ACTION:**

**The Board of Directors recommends that:**

**The House of Delegates ADOPT *Model Guidelines for the Recommendation of Marijuana in Patient Care*.**

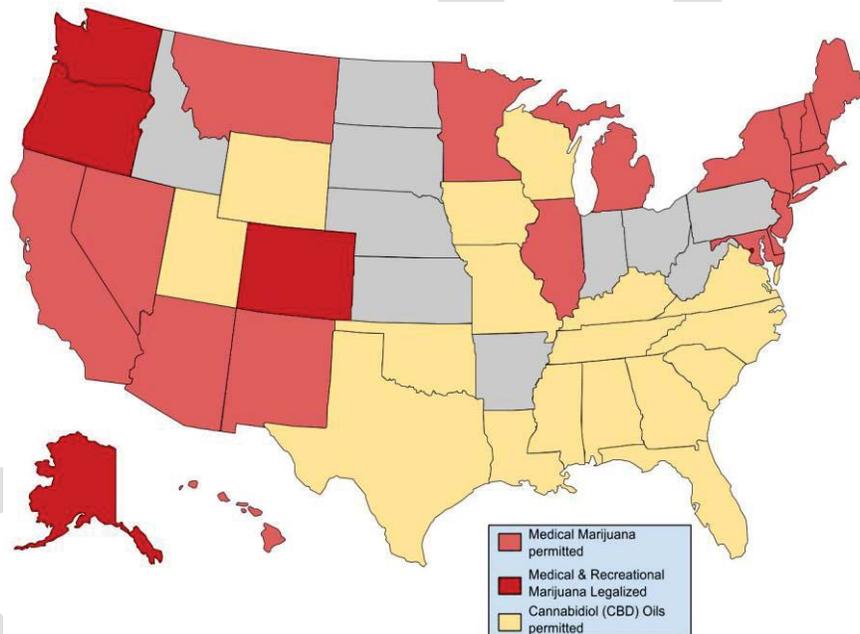
# **Attachment 1**



1 **Section One. Background.**

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

13  
14 **Figure 1: State Map of Marijuana and Cannabidiol Oils Laws**



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

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

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

11  
12 Providers and state regulators should continue to monitor usage and adverse effects of marijuana.  
13 See Figure 2. Based on the increasing number of states permitting the recommendation of  
14 marijuana in patient care, the U.S. Department of Justice updated its marijuana enforcement  
15 policy in August 2013. The updated policy reiterates marijuana’s classification as an illegal  
16 substance under federal law, but advises states and local governments that authorize marijuana-  
17 related conduct to implement strong and effective regulatory and enforcement systems to address  
18 any threat state laws could pose to public safety, public health, and other interests. Should these  
19 state efforts be insufficient, the federal government may seek to challenge the regulatory  
20 structure itself and bring forward individual enforcement actions.<sup>6</sup>

21  
22 The Guidelines that follow are designed to communicate to state medical board licensees that if  
23 marijuana is recommended, these recommendations should be consistent with accepted  
24 professional and ethical practices.  
25

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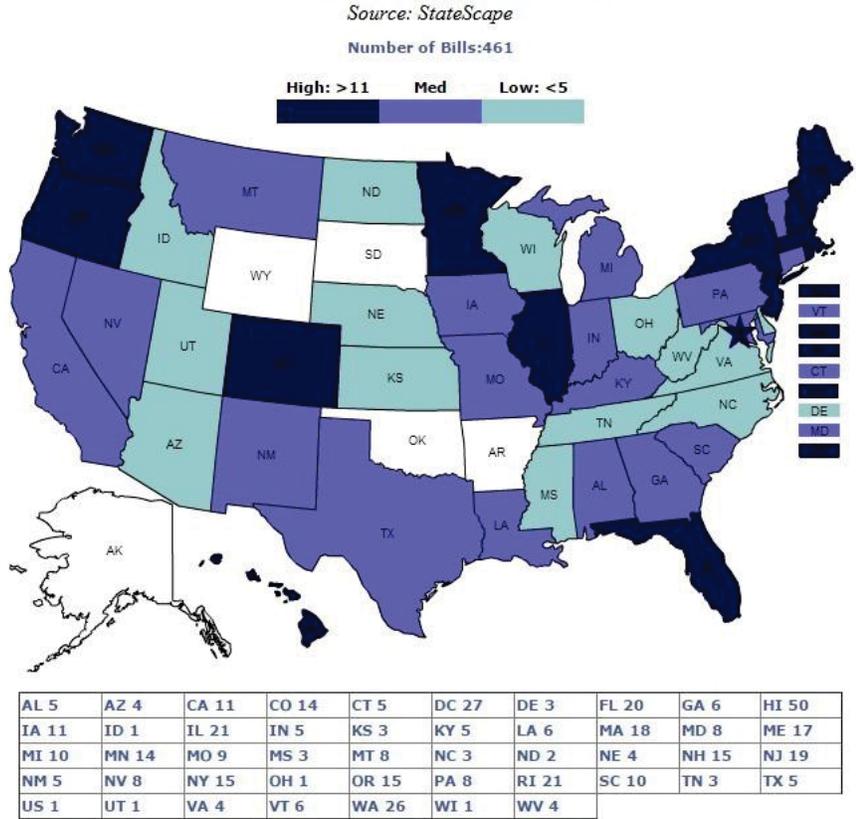
<sup>3</sup> 21 U.S.C. §812.

<sup>4</sup> 21 U.S.C. §841-44.

<sup>5</sup> 18 U.S.C. §2; 21 U.S.C. §846.

<sup>6</sup> James M. Cole, “Guidance Regarding Marijuana Enforcement [Memorandum],” Washington, DC: Department of Justice. (August 19, 2013).

1 **Figure 2: Marijuana Legislation (2013-2015)**



2 **Section Two. Definitions.**

3

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

5

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

11

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

17

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

1 “Tetrahydrocannabinol (THC)” means the primary psychoactive compound in cannabis, delta-9-  
2 tetrahydrocannabinol (THC), which is a partial agonist at cannabinoid receptors in the body.  
3  
4

### 5 **Section Three. Guidelines.**

6

7 The [Name of Board] has adopted the following guidelines for the recommendation of marijuana  
8 in patient care:  
9

10 ***Physician-Patient Relationship:*** The health and well-being of patients depends upon a  
11 collaborative effort between the physician and the patient. The relationship between a patient  
12 and a physician is complex and based on the mutual understanding of the shared responsibility  
13 for the patient’s health care. The physician-patient relationship is fundamental to the provision  
14 of acceptable medical care. Therefore, physicians must have documented that an appropriate  
15 physician-patient relationship has been established,<sup>7</sup> prior to providing a recommendation,  
16 attestation, or authorization for marijuana to the patient. Consistent with the prevailing standard  
17 of care, physicians should not recommend, attest, or otherwise authorize marijuana for  
18 themselves or family member.  
19

20 ***Patient Evaluation:*** A documented in-person medical evaluation and collection of relevant  
21 clinical history commensurate with the presentation of the patient must be obtained before a  
22 decision is made as to whether to recommend marijuana for medical use. At minimum, the  
23 evaluation should include the patient’s history of present illness, social history, past medical and  
24 surgical history, alcohol and substance use history, family history with emphasis on addiction or  
25 mental illness/ psychotic disorders, physical exam, documentation of therapies with inadequate  
26 response, and diagnosis requiring the marijuana recommendation.  
27

28 ***Informed and Shared Decision Making:*** The decision to recommend marijuana should be a  
29 shared decision between the physician and the patient. The physician should discuss the risks  
30 and benefits of the use of marijuana with the patient. Patients should be advised of the  
31 variability and lack of standardization of marijuana preparations and the effect of marijuana.  
32 Patients should be reminded not to drive or operate heavy machinery while under the influence  
33 of marijuana. If the patient is a minor or without decision-making capacity, the physician should  
34 ensure that the patient’s parent, guardian or surrogate is involved in the treatment plan and  
35 consents to the patient’s use of marijuana.  
36

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

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

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

24  
25 **Qualifying Conditions:** At this time, there is a paucity of evidence for the efficacy of marijuana  
26 in treating certain medical conditions. Recommending marijuana for certain medical conditions  
27 is at the professional discretion of the physician. The indication, appropriateness, and safety of  
28 the recommendation should be evaluated in accordance with current standards of practice and in  
29 compliance with state laws, rules and regulations which specify qualifying conditions for which  
30 a patient may qualify for marijuana.

31  
32 **Ongoing Monitoring and Adapting the Treatment Plan:** Where available, the physician  
33 recommending marijuana should register with the appropriate oversight agency and provide the  
34 registry with information each time a recommendation, attestation, authorization, or  
35 reauthorization is issued [see Appendix 1]. Where available, the physician recommending  
36 marijuana should check the state Prescription Drug Monitoring Program (PDMP) each time a  
37 recommendation, attestation, authorization, or reauthorization is issued.

38  
39 The physician should regularly assess the patient's response to the use of marijuana and overall  
40 health and level of function. This assessment should include the efficacy of the treatment to the  
41 patient, the goals of the treatment, and the progress of those goals.

42  
43 **Consultation and Referral:** A patient who has a history of substance use disorder or a co-  
44 occurring mental health disorder may require specialized assessment and treatment. The  
45 physician should seek a consultation with, or refer the patient to, a pain management, psychiatric,  
46 addiction or mental health specialist, as needed.

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

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

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

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1 **Appendix 1: Registration**

2  
3 Many states that permit the recommendation of marijuana to patients for the treatment of serious  
4 medical conditions have laws establishing a registry to track and monitor the utilization of  
5 marijuana in patient care.<sup>8</sup>

6  
7 In these states, physicians recommending marijuana to patients for the treatment of conditions  
8 are required to register with the regulatory agency overseeing the marijuana program, and must  
9 provide the registry with information each time a recommendation is issued.

10  
11 The state's registry is required by law to regularly perform analyses of the number of  
12 recommendations issued. With the statistical review of physician recommendations, the  
13 regulating agency periodically determines whether a physician should be referred to the state  
14 medical or osteopathic board for review and possible sanction.

15  
16 The following are common factors oversight agencies rely on in referring physicians to the state  
17 board for possible abuse of marijuana recommendations:

- 18  
19 1. Physician caseload as determined by the number of patients for whom marijuana is  
20 recommended. A high caseload is calculated as 3,521 or more patient  
21 recommendations in one year for a general practitioner. This reflects the  
22 recommendation of patients equal to or greater than the national average of patient  
23 visits per year for a generalist physician as reported by the Centers for Disease  
24 Control and Prevention (Co. Registry Policy # 2014-04\_001);  
25 2. The plant and ounce recommendations by the physician. Physicians recommending  
26 an amount of marijuana above the standard set within a state's statutes will be  
27 referred to the state medical board for review;  
28 3. Age demographics of the patient caseload. According to the CDC, older adults have a  
29 significantly higher prevalence of chronic conditions than younger adults. Physicians  
30 for whom more than one-third of the patient caseload is under the age of 30 may be  
31 recommended for referral; and  
32 4. Other circumstances determined by the overseeing agency. The oversight agency may  
33 also refer physicians to the state medical board if there is evidence of potential  
34 violation of the constitution, statutes, state medical board regulations or any violation  
35 of the Medical Practice Act.

36  
37 If evidence supports a referral, the overseeing agency will issue a formal referral to the state  
38 medical board with the physician's identifying information, the reason for the referral, and any  
39 statistical data supporting the referral. Once the referral is received, the state medical board  
40 typically reviews the documentation and conducts an investigation as deemed appropriate.

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<sup>8</sup> See e.g. Colorado Medical Marijuana Registry; See e.g. Minnesota Medical Cannabis Registry

## **WORKGROUP MEMBERS**

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

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

Eric R. Groce, DO  
President, Colorado Medical Board

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

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

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

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

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

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

## **EX OFFICIOS**

J. Daniel Gifford, MD, FACP  
Chair, FSMB

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

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

## **STAFF SUPPORT**

Lisa A. Robin  
Chief Advocacy Officer, FSMB

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

John P. Bremer  
State Legislative & Policy Coordinator, FSMB

Federation of State Medical Boards  
House of Delegates Meeting  
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Subject: Physicians' Use of Marijuana

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Approved: February 2016

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**Whereas,** Twenty-four (24) States, plus the District of Columbia and Guam, have enacted laws permitting physicians to recommend marijuana in managing certain medical conditions and seventeen(17) states permit the limited use of cannabidiol (CBD) oils in patient care;

**Whereas,** Four (4) states and the District of Columbia have legalized the adult use of marijuana and several other jurisdictions are considering similar efforts;

**Whereas,** Marijuana is currently classified in federal law as a Schedule 1 substance under the Controlled Substance Act;

**Whereas,** The Federation of State Medical Boards' (FSMB) model policy, *Essentials of a State Medical and Osteopathic Practice Act* (HOD 2015), includes the "habitual or excessive use or abuse of drugs, alcohol or other substances that impair ability" in its definition of unprofessional conduct;

**Whereas,** There is known difficulty in determining and monitoring the amount of marijuana that would impair a physician's ability to practice medicine;

**Whereas,** Practicing medicine under the influence of marijuana may constitute unprofessional conduct or incompetence;

Therefore, be it hereby

**Resolved,** That, given the lack of data supporting clinical efficacy and difficulty evaluating impairment, state medical and osteopathic boards advise their licensees to abstain from the use of marijuana, for medical or recreational purposes, while actively engaged in the practice of medicine.

**Resolved,** That the FSMB model policy, *Essentials of a State Medical and Osteopathic Practice Act*, Section IX, Disciplinary Action against Licensees, D(19) be amended to include "marijuana" in the list of substances that impair ability.

## REPORT OF THE BOARD OF DIRECTORS

**Subject:** Report of the FSMB Workgroup on Telemedicine Consultations

**Referred to:** Reference Committee A

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The Federation of State Medical Boards adopted *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine* in 2013 in response to the increasing utilization of telecommunication technologies in direct to consumer health services. In 2014, FSMB Chair, Donald H. Polk, DO, established the Workgroup on Telemedicine Consultations to provide guidance to state medical and osteopathic boards in defining what characterizes a “consultation” when using telemedicine technologies.

Members of the Workgroup were Kenneth B. Simons, MD, Chair; Michael Arambula, MD, PharmD; Michael J. Arnold, MBA; Ronald R. Burns, DO; Anna Earl, MD; Mark A. Eggen, MD; Stephen E. Heretick, JD; Gregory B. Snyder, MD; and Jean Rawlings Sumner, MD. Participating ex officio were: J. Daniel Gifford, MD, FACP; Arthur S. Hengerer, MD, FACS; and Humayun J. Chaudhry, DO, MACP.

Invited experts were: Alexis S. Gilroy, JD; Elizabeth Baney, JD; Greg T. Billings; Sherilyn Z. Pruitt, MPH; and, Thomas G. Zimmerman, DO.

The Workgroup met in Washington, D.C. in September 2015 and by web conference in December 2015 to develop its informational report (**Attachment 1**). The report represents a comprehensive review and analysis of how telemedicine technologies are being used in consultations and how states are regulating those practices. The Workgroup found variance among state statutes and rules defining physician-to-physician consultations and the level of regulation applied to those consultations. Generally, physicians who interact with patients directly must be licensed in each state where patients are located. However, some states carve out “consultations” from their definition of the practice of medicine or among the activities not prohibited by the state medical practice act.

The report that follows contains no policy recommendations but is to inform state medical boards about the types of consultations and regulatory frameworks for the oversight of physicians who offer consulting services via telemedicine technologies. As telemedicine continues to advance and is applied throughout the health care delivery system, the FSMB and state medical boards must continue to monitor and identify best practices in the interest of improved patient care and safety.

### **ITEM FOR ACTION:**

**No action required; report is for information only.**

# **Attachment 1**

## REPORT OF THE FSMB WORKGROUP ON TELEMEDICINE CONSULTATIONS

### EXECUTIVE SUMMARY

The Federation of State Medical Boards (FSMB) adopted a *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine* in 2013 in response to the increasing utilization of telecommunications technologies in the delivery of health care. A comprehensive review and analysis by the FSMB's Workgroup on Telemedicine Consultations reveals there is variance among state statutes and rules defining physician-to-physician consultations, with or without the use of telemedicine, and more than one approach to their permissiveness of telemedicine consultations by physicians licensed outside the jurisdiction where the patient is located. This informational report outlines the existing state regulatory framework for the oversight of consulting physicians using telemedicine, noting the value of continued monitoring by state medical boards of advances in telemedicine technologies, practices and regulations as best practices emerge that promote patient safety and protect the public.

### INTRODUCTION

The Federation of State Medical Boards (FSMB) adopted *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine* in 2013 in response to the increasing utilization of telecommunications technologies in direct to consumer services and the associated paucity of relevant state policy. Within the policy, telemedicine is defined as “[t]he practice of medicine using electronic communications, information technology or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider. Generally, telemedicine is not an audio-only, telephone conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, encounter in person between a provider and a patient.”<sup>1</sup> The 2013 policy was designed as both a report for state medical boards and to educate physicians and other health care providers as to the appropriate standards of care when delivering medical services directly to patients via telemedicine technologies.

Because the 2013 policy purposefully did not address the use of telemedicine technologies when physicians solely providing consulting services to another physician, FSMB's Chair, Donald H. Polk, DO, established the Workgroup on Telemedicine Consultations in 2014 to review current state laws, rules, regulations and policies related to consultations with the goal of developing a consensus around what may characterize a “consultation” when using telemedicine technologies. In addressing its scope of work, the Workgroup conducted a review of telemedicine services and how they are being used in physician-to-physician consultations as well as how such consultations are currently being regulated by state medical boards, including requirements for licensure. The following report, intended only to address physician-to-physician consultations for which there is remuneration (excluding informal second opinion activities and other “curb side” interactions among physicians), outlines the existing state regulatory framework for the oversight of the consulting physician using telemedicine technologies.

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<sup>1</sup>FSMB Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine (2013), p. 4.

## **FINDINGS**

The Workgroup's comprehensive review of state medical board statutes and rules, as related to consultations and those specifically facilitated by telemedicine, reveals ambiguity among state definitions of consultations, whether utilized with or without telemedicine. A physician-to-physician consultation is generally understood to be an episodic interaction between physicians. Services usually originate from health care systems, hospitals or large medical group practices that employ a diverse collection of expert and highly experienced medical and healthcare specialists.<sup>2</sup>

In practice, consultations by telemedicine are common today among physicians, who increasingly communicate with patients, colleagues, physicians, or other health care personnel at physically separate and disparate locations through telecommunications, information technologies, and other tools to exchange medical information. These technologies range from the use of complex live, interactive videoconferencing with corresponding examination devices, to simple image capture and transmission for storage and review. The physician consultant in this context typically examines the patient and may order diagnostic tests or provide treatment directly. The consultant is usually reimbursed the same amount as if he or she had seen the patient in his or her own office.<sup>3</sup>

## **TYPES OF CONSULTATIONS**

### **a. LIVE, INTERACTIVE VIDEO CONFERENCING**

Many consultations occur through live, two-way interactive videoconferences connecting consulting physicians, in real-time, to the requesting care provider while the two parties are at different geographic locations.<sup>4</sup> The consulting physician is often located either in a special facility designed for telemedicine or in his or her office. The patient is typically at a different location, such as a clinic, nursing home or hospital, and may be accompanied by an amanuensis or telemedicine presenter, who is on staff at that location. Communication is usually facilitated by using secure digital video conferencing wherein the consultant's image is captured by a video camera, digitized and transmitted over secure, broadband speed telecommunications lines to where the patient is located and where it appears on a video screen to be viewed by the patient. At the same time, the patient's image is captured by a similar process and transmitted to a video screen for viewing by the consultant. The real-time conversations between the patient, on-site provider and consulting physician are captured and transmitted in the same way, ultimately enabling the consulting physician and the patient to conduct conversations as if they were in

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<sup>2</sup>Specialties utilizing telemedicine services include: Allergy/Immunology; Anesthesiology; Cardiology; Critical Care; Dentistry; Dermatology; Otolaryngology (ENT); Emergency Medicine; Endocrinology; Family/General Practice; Gastroenterology; Infectious Diseases; Internal Medicine; Maternal/Fetal Medicine; Mental/Behavioral Health; Neurology; Oncology/Hematology; Ophthalmology/Optomety; Orthopedics; Pathology; Pediatrics; Psychiatry; Pulmonology; Rehabilitative Medicine; Rheumatology; Surgery; Urology.

<sup>3</sup><http://www.telehealthresourcecenter.org/toolbox-module/types-telemedicine-specialty-consultation-services>

<sup>4</sup><http://cchpca.org/what-is-telehealth/video-conferencing>

the same room.<sup>5</sup> It is also common for consulting physicians to interact directly with the requesting care provider through these mechanisms, sometimes without the patient as an intermediary.

Live, two-way videoconferencing is frequently used in small communities without medical specialists physically available. For example, in rural areas without specialized psychiatrists, mental health clinicians and family physicians schedule consultations for patients with psychiatrists based in teaching hospitals. Patients are interviewed by remote consultation, and recommendations concerning ongoing management are immediately provided to the relevant local health care provider. Similar scheduled consultations now occur in the fields of internal medicine, rehabilitation, cardiology, pediatrics, obstetrics/gynecology, and neurology, although these specialties may require the presence of a local care provider to perform any physical examinations that may be required. Increasingly, many peripheral devices, such as electronically-enhanced stethoscopes and otoscopes, can be attached to the VC equipment to aid in the interactive examination.

Consultations involving live, two-way video conferencing are credited with improved access to specialty consultations by patients in rural or otherwise underserved areas. In addition, the cost to patients is also mitigated by live, two-way video conferencing consultations by reducing the need for the patient (or the consulting provider) to travel large distances over an extended period of time. Further, live, two-way video conference consultations facilitate interactions that allow for immediate clinical feedback to the patient and referring physician or health care professional.

However, it should be noted that drawbacks to consultations facilitated by live, two-way video conferencing exist. In particular these types of consultations require appropriate bandwidth, customized telecommunications networks, and highly specialized equipment, which can all significantly increase cost. Moreover, some situations and patient presentations (e.g., loss of consciousness, paroxysmal cardiac arrhythmia) may not be appropriate for the utilization of live, interactive video conferencing and may be better managed in person or in an acute care setting by an appropriately trained care provider without delay.

#### **b. STORE AND FORWARD**

A store and forward consultation is one in which information is captured from the patient at one time and location and is evaluated by a consultant at a different time and location. Packages of digital information are captured and “stored” and then transmitted/“forwarded” to another location for evaluation. The consultant accesses both the digital images and the clinical information, and then interprets and sends a report back to the original location.

Teleradiology is the most widely recognized and used type of store-and-forward consultation.<sup>6</sup> In a typical teleradiology consultation, a practitioner in a small town without local expertise sends radiographic images over the Internet to a radiologist in a larger urban health care institution. The radiologist views the images and then sends an interpretation of the image back to the requesting

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<sup>5</sup> <http://www.telehealthresourcecenter.org/toolbox-module/types-telemedicine-specialty-consultation-services>

<sup>6</sup> <http://www.telehealthresourcecenter.org/toolbox-module/types-telemedicine-specialty-consultation-services>

provider. Images of X-rays, CT scans, and MRIs today are all routinely stored-and-forwarded at hundreds of health care facilities. Images of pathology slides, skin conditions, and the retina are also commonly transmitted using this telemedicine model for diagnostic consultation.<sup>7</sup>

Advantages of the store and forward consultation model include reduced dependency on bandwidth and expensive customized networks and equipment, and increased flexibility for consultants in terms of accessing images at their convenience.<sup>8</sup> Disadvantages may include inappropriateness for emergency situations where consultant opinions cannot be delayed, and inefficiency due to lack of real-time interaction between the patient, the local health care professional, and the consultant.<sup>9</sup>

### c. OTHER

While live, video conferencing consultations and store and forward consultations are the two most utilized forms of telemedicine consultations in practice, there are a number of other noteworthy forms of consultation.

For example, hybrid consultations use components of live, interactive and store-and-forward consultations. Typically, these are used in specialties that require higher quality images than those provided by standard video while also necessitating direct patient interaction, such as in dermatology or cardiology.<sup>10</sup>

Emergency consultations or “just-in-time consultation on demand (JITCOD)” differ from both store and forward and live, video conferencing consultations in that the consultation occurs unexpectedly, at the time that the need arises. Emergency consultations most commonly apply in situations in which a critically ill patient needs immediate treatment and the attending physician initiates a telemedicine consultation at his or her discretion, making contact with a consultant ready to provide a synchronous discussion of patient management recommendations. For example, when an emergency department trauma patient cannot be airlifted from a regional hospital due to weather-related flight restrictions, a remote consulting physician may consult with the general surgeon in the ED and guide the surgeon in performing a critical procedure, allowing for real-time provision of consultation and immediate co-management of critical cases.<sup>11</sup>

### LICENSURE

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<sup>7</sup> <http://www.bcmj.org/article/videoconferencing-telehealth-unexpected-challenges-and-unprecedented-opportunities#3>

<sup>8</sup> <http://cchpca.org/store-and-forward>

<sup>9</sup> <http://www.bcmj.org/article/videoconferencing-telehealth-unexpected-challenges-and-unprecedented-opportunities#3>

<sup>10</sup> <http://www.telehealthresourcecenter.org/toolbox-module/types-telemedicine-specialty-consultation-services>

<sup>11</sup> Lambrecht CJ. Emergency physicians’ roles in a clinical telemedicine network. *Ann Emerg Med* 1997;30:670-674; Ho K, Jarvis-Selinger S, Novak Lauscher H, et al. Just-in-time support: Understanding the impact on rural communities through physicians’ perceptions of on-demand emergency and trauma teleconsultations. Paper presented at: Canadian Society of Telehealth Annual Conference. 3–5 October 2002; Vancouver, British Columbia.

Telemedicine consultations raise numerous legal and regulatory concerns, particularly in the area of medical licensure. State medical boards and state statutes generally concur that a physician must be licensed, or under the jurisdiction of, the medical board of the state or territory where the patient is located, regardless of whether the services are provided in person or remotely. Physicians who treat and/or prescribe to patients using online services sites are, therefore, considered to be engaged in the practice of medicine and must possess appropriate licensure in all jurisdictions where patients receive care.<sup>12</sup>

While the majority of telemedicine consultations will likely occur between and among physicians located within the state where the patient is located, a physician who electronically interacts directly with patients in other states must generally be licensed (or registered) in each state where that electronic practice is occurring. Depending on the state-specific rules and regulations, however, there are certain circumstances in which a physician may be exempted from state licensure requirements, as when the physician consults with an in-state licensed physician who maintains a physician-patient relationship with the subject patient and does not interact directly with the patient. Some states also articulate specific exceptions for physician-to-physician consultations, while other state rules are ambiguous.

#### **a. GENERAL PROVISIONS**

State medical boards generally address consultations within the licensure sections of their respective Medical Practice Act and corresponding regulations requiring, at minimum, physicians who perform consultation services within the governing state medical boards' jurisdiction to be authorized to practice medicine in another state.<sup>13</sup> A few boards carve out consultations as an activity not covered under their Medical Practice Act,<sup>14</sup> stating that performing a consultation is not within their state's definition of the practice of medicine.<sup>15</sup> Other boards exempt consultations from the category of activities considered to be the unlawful practice of medicine,<sup>16</sup> consider consultations among the activities not to be interpreted to be prohibited by their Medical Practice Act<sup>17</sup> or one that does not require a medical license from the board.<sup>18</sup>

Examining the full range of existing statutory and regulatory provisions governing consultations reveals three distinct approaches to licensure or licensure exemptions as related to consultations. First, state medical boards may exempt physicians from licensure requirements, depending on how often they consult with another physician in their jurisdiction. Second, state medical boards may condition the licensing exemption on whether or not the consulting physician maintains a place of business in the state. The third approach is to exempt the consulting physician licensing requirements altogether, as long as he or she does not exercise ultimate authority over the patient's primary care.

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<sup>12</sup> FSMB Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine (2013), pg. 5.

<sup>13</sup> See e.g. Arizona; District of Columbia; Hawaii.

<sup>14</sup> See e.g. New Mexico; New Hampshire; West Virginia.

<sup>15</sup> See e.g. Georgia; Oklahoma; North Carolina;

<sup>16</sup> See e.g. Indiana; Nebraska.

<sup>17</sup> See e.g. Oregon; Washington-M.

<sup>18</sup> See e.g. Mississippi.

## 1. IRREGULAR, INFREQUENT, EPISODIC

The most common mechanism to regulate consultations by state boards is by conditioning exceptions to licensure on whether the physician not residing in the state who, while located outside of the regulating state, consults on an irregular basis with a licensed physician who is located in, and licensed by, the state.<sup>19</sup> It is noteworthy that many state boards consider consultations to be outside the scope of their Medical Practice Act if the consultation is irregular, infrequent, or episodic.<sup>20</sup>

Within this category of state medical board regulations, some leave open for interpretation how many interactions would constitute “irregular,” while a number of boards specify a threshold number of consultations that would be permitted under its rules as a consultation not necessitating licensure.<sup>21</sup> For example, in Minnesota, a physician who is not licensed to practice medicine in Minnesota but who holds a valid license to practice medicine in another state, and who provides interstate telemedicine services to a patient located in Minnesota on an irregular or infrequent basis, need not register with the Minnesota Board of Medical Practice.<sup>22</sup> Minnesota also defines “irregular or infrequent basis” as the provision of services “less than once a month” or involving “fewer than ten patients annually.”<sup>23</sup> In Delaware, the Delaware Board of Medical Licensure and Discipline does not require “infrequency” per se, but limits the number of permitted unlicensed consultations to no more than twelve (12) times each year.<sup>24</sup>

## 2. NO OFFICE/DESIGNATED PLACE TO MEET PATIENTS

It is not uncommon for authorizing statutes or rules governing telemedicine consultations, as opposed to the full practice of medicine, to prohibit the maintenance by the physician of a physical location or office within the state.<sup>25</sup>

In a few limited instances, some state boards’ consultation rules only permit non-office, unlicensed consultations within the state by lawfully licensed physicians in states that border or adjoin the regulating state.<sup>26</sup> For example, the New York State Board for Medicine’s consultation rules state:

“Any physician who is licensed in a bordering state and who resides near a border of this state, provided such practice is limited in this state to the vicinity of such border and provided such physician does not

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<sup>19</sup> See *e.g.* Connecticut.

<sup>20</sup> Alabama; Arizona-M; Arkansas; Connecticut; Colorado; District of Columbia; Illinois; Iowa; Kentucky; Main-M; Michigan; Minnesota; New Mexico-M; North Carolina; New Hampshire; Oklahoma-O; Ohio; Rhode Island; Tennessee-M; Texas; West Virginia-M; Wyoming.

<sup>21</sup> See *e.g.* Alabama; Delaware; Rhode Island; Tennessee; West Virginia; Wyoming.

<sup>22</sup> See Minn. Stat. Ann. § 147.032.

<sup>23</sup> See Minn. Stat. Ann. § 147.032.

<sup>24</sup> See Delaware.

<sup>25</sup> See Arizona-O; CA-M; Colorado; Georgia; Hawaii; Idaho; Kansas; Maryland; Michigan; Montana; Nebraska; New Hampshire; New Jersey; New York; Ohio; Texas; Washington-M; Washington-O.

<sup>26</sup> See Maryland; Michigan; New Hampshire; New York; Ohio.

maintain an office or place to meet patients or receive calls within this state [may practice medicine within the state without a license].”<sup>27</sup>

### **3. NO ULTIMATE AUTHORITY OVER PATIENT’S PRIMARY CARE**

A third common means of regulating consultations is to allow the unlicensed practice of medicine within the state’s jurisdiction so long as the out-of-state consultant does not exercise ultimate authority over the patient’s primary care.<sup>28</sup> State boards differ between 1) specifying whether the consultant may or may not be the physician of record;<sup>29</sup> 2) prohibiting the consultant from directing patient care;<sup>30</sup> 3) requiring an in-state physician to supervise the consultant<sup>31</sup> or remain responsible<sup>32</sup> for the case; or 4) prohibiting a consultant from performing medical procedures.<sup>33</sup> For example, the Louisiana State Board of Medical Examiners exempts “true” consultations from its telemedicine standards “provided that the Louisiana physician receiving the opinion is personally responsible to the patient for the primary diagnosis and any testing and treatment provided.”<sup>34</sup>

### **4. OTHER**

In addition to the above mentioned distinctions among state medical board consultation regulations, a small number of state boards suspend licensure requirements for out-of-state physicians treating their preexisting patients temporarily in another state. In these instances, state medical boards consider a valid consultation to exist when the pre-existing patient is in the regulating state temporarily, or when the consultant provides follow-up care to treatment previously performed in the consultant’s state of licensure.<sup>35</sup> The Massachusetts Board of Registration in Medicine exempts physicians authorized to practice medicine in another state from licensure requirements, “when (that physician) is called as the family physician to attend a person temporarily abiding in the Commonwealth.”<sup>36</sup> It should also be noted that Georgia, Nevada, New Jersey, and South Carolina permit consultations by either direct board approval or board opinion only.<sup>37</sup>

To help fulfill their mission to promote patient safety and protect the public, state medical boards will need to continue to monitor advances in telemedicine technologies, practices and regulations as best practices emerge in the delivery of quality health care using physician-to-physician telemedicine consultations.

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<sup>27</sup> See N.Y. Educ. Law § 6526 (McKinney).

<sup>28</sup> See California-M; Delaware; Florida-M; Florida-O; Hawaii; Illinois; Minnesota; Louisiana; Maryland; Maine-M; Missouri; New Hampshire; Ohio.

<sup>29</sup> See e.g. Maine-M.

<sup>30</sup> See e.g. Maryland.

<sup>31</sup> See e.g. Florida-O.

<sup>32</sup> See e.g. Delaware.

<sup>33</sup> See e.g. Florida-M.

<sup>34</sup> See 46 La. Admin. Code Pt XLV, 7515.

<sup>35</sup> See Indiana; Illinois; Massachusetts; North Carolina; Ohio; Virginia.

<sup>36</sup> See Mass. Gen. Laws Ann. ch. 112, § 7.

<sup>37</sup> See Georgia, Nevada, New Jersey, and South Carolina.

## Additional Resources

- Center for Telehealth and E-Health Law – <http://www.ctel.org/>,  
<http://www.telehealthlawcenter.org/>.
- The Northwest Regional Telehealth Resource Center – <http://www.nrtrc.org/index.html>.
- The Great Plains Telehealth Resource and Assistance Center (TRAC) –  
<http://gptrac.ahc.umn.edu/>.
- Northeast Telehealth Resource Center – <http://www.netrc.org/>.
- The California Telehealth Resource Center (CTRC) – <http://www.caltrc.org/>.
- The Midwest Alliance for Telehealth & Technology Resources (MATTeR) –  
<http://www.midwesttrc.org/>.
- HRSA’s Office for the Advancement of Telehealth – <http://www.hrsa.gov/telehealth/default.htm>.
- The Centers for Medicare & Medicaid – <http://www.cms.hhs.gov/default.asp?>.
- Lynn D. Fleisher, James C. Dechene, TELEMEDICINE AND E-HEALTH LAW (2015).

## APPENDIX I. ENVIRONMENTAL SCAN

Virtual doctor visits are rapidly gaining popularity as more health insurers offer telemedicine services.

- MDLive
  - Currently #2 in market share, MDLive offers immediate access to doctors and therapists 24/7/365 through video or phone consultations for \$45 per consultation or by monthly plan. MDLive quotes an 11 minute response time. Its investors include the Heritage group.<sup>38</sup>
- Teladoc
  - Currently #1 in market share, Teladoc offers 24/7 access to US doctors by phone and online video consultations for \$38 per consultation + an annual fee (4150 or less). Teladoc quotes a 16 minute average callback time.<sup>39</sup>
    - Consult A Doctor: Acquired by TelaDoc in 2013<sup>40</sup>
    - AmeriDoc: Acquired by TelaDoc in 2014<sup>41</sup>
- American Well
  - With beginnings in building telemedicine portals for hospitals, American Well now provides 24/7/365 on-demand video consultation doctor services for \$49.95 per 10 minutes.<sup>42</sup>
- Doctor on Demand
  - Doctor on Demand offers video consultations on iOS and Android devices from 4am-11pm PST in 31 states for \$40 per 15 minutes.<sup>43</sup>
- HealthTap
  - Offers unlimited 24/7 live phone, video, and chat consultations for \$99 per month. HealthTap also offers actionable health checklist, news, and tips personalized by a doctor.<sup>44</sup>
- WellPoint LiveHealth Online

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<sup>38</sup> <https://mdlive.com/>

<sup>39</sup> <http://www.teladoc.com/>

<sup>40</sup> <http://www.consultadr.com/>

<sup>41</sup> <http://www.ameridoc.com/>; <http://www.teladoc.com/news/2014/05/09/teladoc-acquires-ameridoc/>

<sup>42</sup> <https://www.americanwell.com/>

<sup>43</sup> <http://www.doctorondemand.com/>

<sup>44</sup> <https://www.healthtap.com/>; <https://vsee.com/blog/healthtap-doctors-virtual-video-visits/>;

<http://www.forbes.com/sites/parmyolson/2014/07/30/healthtap-offers-uber-like-service-for-seeing-a-doctor/>

- LiveHealth Online, powered by AmericanWell/Vidyo, is now administered as part of WellPoint/Anthem health plans in 44 states and offers unlimited 24/7 live phone, video and chat consultations on iOS and Android mobile apps for \$49 per visit or co-pay if the service is not fully covered by a health plan<sup>45</sup>
- Specialists On Call
  - Specialists on Call is the oldest telemedicine service operating and offers a 24/7/365 call center with video conferencing endpoints with varying fees depending on the service provided. Specialists On Call quotes a 15 minute response time.<sup>46</sup>
- Virtuwell
  - Part of Health Partners<sup>47</sup> offering diagnosis and treatment plans in 30 mins through a 24/7 online clinic for \$40 per consultation or insurance co-pay.<sup>48</sup>
- Ringadoc: phone triage answering service for doctors for \$69 per month per provider<sup>49</sup>
- 2nd.MD: direct access to U.S. medical specialists for patients with video and phone consultations and specialist consultation in 3 days for \$30000 per case<sup>50</sup>
- StatDoctors: scheduled or on-demand virtual consultations 24/7 by board-certified ER physicians on an employer contracted basis. Quote a 6 minute average wait time.<sup>51</sup>
- MeMD: video consultations from 7am-10pm, 7days/week with a wait time of 30 minutes or less for \$49.95 per consult.<sup>52</sup>
- Interactive MD: online doctor consultations via video conference, phone and email for \$9.99 per month + \$40 per diagnostic consult + \$15.00 enrollment fee.<sup>53</sup>
- RapidRemedy: Real-time video consultations, Monday-Thursday 8am-8pm, Friday 8am-5pm, and Saturday 8am-noon, starting at \$8.95 per month per individual, with a 2 minute response time<sup>54</sup>

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<sup>45</sup> <https://livehealthonline.com/>; <http://mobihealthnews.com/33816/wellpoint-now-offering-mobile-video-visits-with-physicians-in-44-states/>

<sup>46</sup> <http://specialistsoncall.com/>

<sup>47</sup> <https://www.healthpartners.com/public/>

<sup>48</sup> <https://www.virtuwell.com/>

<sup>49</sup> <https://www.ringadoc.com/>

<sup>50</sup> <http://2nd.md/>

<sup>51</sup> <http://statdoctors.com/>

<sup>52</sup> <http://www.memd.me/>

<sup>53</sup> <http://www.interactivemd.com/>

<sup>54</sup> <http://rapidremedy.com/>

- USARAD: “Radiology-on-demand” platform offering 24/7/365 radiology and teleradiology services and interpretation consults by US radiology experts with a 15 minute wait time for ER cases.<sup>55</sup>
- Second Opinions: Provides second opinion consultations in all areas of medicine, including radiology to connect patients with US specialist doctors 24/7/365 via email, phone and video consults for \$49+. Second Opinions quotes a 1-24hour turnaround time.<sup>56</sup>
- MyidealDoctor: <http://www.myidealdocor.com/>
- NowClinic: <https://nowclinic.com/landing.htm>
- Sherpaa (New York) <https://sherpaa.com/>
- Retrace Health (Minnesota): <https://retracehealth.com/>
- CareSimple: <https://www.caresimple.com/>

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<sup>55</sup> <http://usarad.com/>

<sup>56</sup> <https://www.secondopinions.com/>

**2015-2016 WORKGROUP ON TELEMEDICINE  
CONSULTATIONS**

Kenneth B. Simons, MD (Chair)  
Chairperson, Wisconsin Medical Examining Board

Michael R. Arambula, MD  
President, Texas Medical Board

Michael J. Arnold, MBA  
Public Member, North Carolina Medical Board

Elizabeth Baney, JD  
FWD Strategies International, LLC

Greg T. Billings  
Center for Telehealth and eHealth Law

Ronald R. Burns, DO  
Former Chair, Florida Board of Osteopathic Medicine

Anna Earl, MD  
Member, Montana Board of Medical Examiners

Mark A. Eggen, MD  
President, Minnesota Board of Medical Practice

Alexis S. Gilroy, JD  
Jones Day LLP

Stephen E. Heretick, JD (FSMB Board of Directors)  
Former Chair, Virginia Board of Medicine

Sherilyn Z. Pruitt, MPH  
Director, HRSA Office for the Advancement of  
Telehealth

Gregory B. Snyder, MD (Board of Directors)  
Former President, Minnesota Board of Medical Practice

Jean R. Sumner, MD (FSMB Associate Member)  
Former Chair, Georgia Composite Medical Board

Thomas G. Zimmerman, DO  
AOA of Medical Informatics (AOAMI)

**Ex-Officio:**

J. Daniel Gifford, MD, FACP  
Chair, FSMB Board of Directors

Arthur S. Hengerer, MD  
Chair-elect, FSMB Board of Directors

Humayun "Hank" Chaudhry, DO, MACP  
FSMB President & CEO

**FSMB Support Staff:**

Lisa Robin  
FSMB Chief Advocacy Officer

Shiri A. Hickman, JD  
Director, State Legislation & Policy

John P. Bremer  
State Legislative & Policy Coordinator



## **TAB H: Report of Reference Committee B**

### **MANAGEMENT NOTE:**

The following resolution and report will be submitted to Reference Committee B:

1. [BRD RPT 16-1](#): Ethics and Professionalism Committee Position Statements
  - a. Practice Drift
  - b. Duty to Report
  - c. Sale of Goods by Physicians and Physician Advertising
  - d. Compounding of Medications by Physicians
  
2. [Resolution 16-1](#): Task Force to Study the Need for State Board Regulation of Physician Compounding (NC)

## REPORT OF THE BOARD OF DIRECTORS

**Subject:** Ethics and Professionalism Committee Position Statements

**Referred to:** Reference Committee B

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The Federation of State Medical Boards (FSMB) Ethics and Professionalism Committee, chaired by FSMB Chair-elect Arthur S. Hengerer, M.D., FACS is a standing committee of the FSMB charged with addressing ethical and professional issues pertinent to medical regulation.

The Committee's 2015-16 work program included conducting a review and update of the *Report of the Special Committee on Professional Conduct and Ethics*. This report addresses a range of issues, including Enhancing Medical Board Authority, Disruptive Behavior, Internet Prescribing, and Sale of Goods from Physician Offices. The FSMB House of Delegates adopted the recommendations contained in this report as policy in April 2000. While several of the recommendations in this report are still relevant and offer helpful guidance to state medical boards, physicians, and other parties, the Committee felt that updates were needed and that new issues have arisen since drafting that should also be addressed.

In completing its work, the Committee met twice via teleconference and once in person on September 29, 2015. In reviewing the *Report of the Special Committee on Professional Conduct and Ethics*, Committee members agreed that the issues identified in the report would be more effectively addressed through individual position statements, rather than in a single document. This may also facilitate the process by which visitors to the FSMB website can search for and find guidance on a particular issue.

In its deliberations, the Committee noted that guidance about Internet Prescribing contained in existing FSMB policies was sufficient and that Disruptive Behavior could be addressed as part of the FSMB's ongoing work on the issue of Physician Burnout. Members determined that updated guidance was necessary on the issues of Sale of Goods from Physician Offices and Enhancing Medical Board Authority. Members felt that the former should be augmented with guidance on Physician Advertising and that the latter should include a focus on equipping state medical boards with the relevant information for fulfilling their missions through an emphasis on the professional duty to report. Finally, Committee members agreed that new position statements should be drafted to address Physician Practice Drift and Compounding of Medications by Physicians.

The Committee drafted four position statements addressing Practice Drift (**Attachment 1**), Duty to Report (**Attachment 2**), Sale of Goods by Physicians and Physician Advertising (**Attachment 3**), and Compounding of Medications by Physicians (**Attachment 4**). Incorporated into these statements is feedback from the FSMB membership and other stakeholders following their

distribution for comment on February 23, 2016. The Board of Directors has approved the position statements and recommends their adoption by the House of Delegates.

**ETHICS AND PROFESSIONALISM COMMITTEE MEMBERS**

Arthur S. Hengerer, MD (Chair)  
Chair-elect, FSMB

Rev. O. Richard Bowyer, MDiv, ThM  
West Virginia Board of Medicine

Claudette E. Dalton, MD  
Virginia Board of Medicine

Mark A. Eggen, MD  
Minnesota Board of Medical Practice

Gerald T. Kaplan, MA  
Minnesota Board of Medical Practice

Lois Snyder Sulmasy, JD (Ethics Consultant)  
ACP Center for Ethics and Professionalism\*

Bruce D. White, DO, JD (Subject Matter Expert)  
Alden March Bioethics Institute

Doris C. Gundersen, MD (Consultant)  
Federation of State Physician Health Programs

**EX OFFICIO**

J. Daniel Gifford, MD, FACP  
Chair, FSMB

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

**STAFF SUPPORT**

Lisa A. Robin  
Chief Advocacy Officer, FSMB

Mark L. Staz, MA  
Director of CPD, FSMB

\* Affiliation for identification purposes only, the views expressed herein do not necessarily represent the policies or views of the American College of Physicians.

**ITEMS FOR ACTION:**

**The Board of Directors recommends that,**

- 1) The House of Delegates ADOPT the position statement of the FSMB on Practice Drift.**
- 2) The House of Delegates ADOPT the position statement of the FSMB on Duty to Report.**
- 3) The House of Delegates ADOPT the position statement of the FSMB on Sale of Goods by Physicians and Physician Advertising.**
- 4) The House of Delegates ADOPT the position statement of the FSMB on Compounding of Medications by Physicians.**

# **Attachment 1**

## Position of the Federation of State Medical Boards

### Practice Drift

When a physician is granted a license by a state medical board in the United States, the physician is given the privilege of practicing the full breadth of medicine. This general undifferentiated license provides physicians with broad discretion to expand, narrow, or alter their areas of practice as they see fit. While many physicians spend their entire careers practicing in the area in which they completed formal medical training, others decide to expand or shift their practice to additional areas beyond their recognized specialty.

In considering changing or expanding their areas of practice, physicians have a professional and ethical duty to put their patients' best interests before their own and only offer treatments to patients that they are able to provide competently.

In recent times, various economic and lifestyle pressures have led to an increase in the rate at which physicians are seeking to change or expand their areas of practice.<sup>1</sup> This can be seen as a positive development for both physicians and the patients they treat: competently meeting patient health needs is an important way in which physicians fulfill their duty of beneficence to patients. Expanding one's area of practice can provide opportunities for alternate specializations to meet patient demands, as well as options for ensuring or increasing career satisfaction. For patients, flexibility in terms of the areas of practice of physicians can provide greater assurances that they will have access to medical care when needs arise.

However, changes in physicians' areas of practice may also present risks to patients in circumstances where a physician is not appropriately trained to provide the treatments that fall within their newly chosen area of practice. As such, it is incumbent upon physicians to ensure that they are able to demonstrate competence in their selected area of practice and that they only provide treatments to patients for which they have received adequate and appropriate training. This will often involve seeking additional training by attending educational programs. Physicians are encouraged to seek information about the quality of any such programs by researching their accreditation status and the nature of any oversight involved.

Additional training sought need not always be limited to formal medical training offered through academic medical centers or continuing medical education providers, but can also include observation of procedures performed by recognized experts, followed by provision of these same procedures under the supervision of a qualified physician. Once a physician has taken the appropriate steps to be able to demonstrate competence in an area outside of their recognized area of practice, it is recommended that the physician determine whether their medical liability insurance adequately covers them in the performance of any new procedures.

Fundamental to the concept of professional self-regulation is the development of principles of medical ethics and the enforcement of professional expectations and standards by the medical profession itself. Hospital administrators should therefore be diligent in monitoring the areas of practice of physicians at the time of reappointment to ensure that adequate training has been

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<sup>1</sup> St. Peter, et al., Changes in the Scope of Care Provided by Primary Care Physicians, *N Engl J Med* 1999; 341:1980-1985

46 received for procedures listed. Where feasible, state medical boards can also monitor physicians'  
47 insurance billing patterns and medical records to determine whether practice areas have shifted  
48 to include non-traditional procedures for given specialties, or whether harms may have resulted  
49 from the performance of procedures in the absence of adequate qualifications or training.

50  
51 It is also essential that patients only seek medical treatment from physicians who are qualified to  
52 provide the medical care that they need. Patients should therefore seek information about  
53 prospective physicians, including the level of experience they have with particular procedures,  
54 their education (especially graduate medical education), and any board certifications held.  
55 Patients are encouraged to ask their physicians about their qualifications for performing  
56 particular procedures and also to consult the Federation of State Medical Boards' [DocInfo](#)  
57 website where they can find information about physicians' education, board certifications, and  
58 any disciplinary actions taken against a physician's license.

59  
60 A related responsibility exists on the part of physicians to clearly inform patients regarding their  
61 training and credentials to perform specific procedures or services. Physicians should also be  
62 prepared to provide information about their qualifications and any additional training undertaken  
63 that has prepared them to provide treatment that falls outside of their original area of practice and  
64 should provide this information to patients as part of the informed consent process.

65  
66 While licenses granted by state medical boards allow licensees to practice the full breadth of  
67 medicine and surgery, boards are nonetheless responsible for ensuring that licensees can practice  
68 competently within their chosen area of practice. In fulfilling this responsibility, state medical  
69 boards are encouraged to collect information about licensees' areas of practice as part of the  
70 license renewal process. This may increase their ability to protect patients within their  
71 jurisdictions in the event that issues with a licensee's area of practice arises. The FSMB has  
72 provided recommendations for categories of information to collect, as well as possible  
73 formatting of questions, in its *Report on a Recommended Framework for a Minimal Physician*  
74 *Data Set*.

# **Attachment 2**

## Position of the Federation of State Medical Boards

### Duty to Report

In order for state medical boards to fulfill their mission to regulate the medical profession in the interests of patients, it is essential that they are equipped with all relevant information that allows them to operate effectively. Some of the information that is pertinent to patient safety and protection is not immediately available to state medical boards in the course of their existing programs and functions. As such, boards rely upon other individuals and entities to submit this information, as necessary.

A sample of relevant categories of information includes patient safety issues and events, observed impairment, incapacity or incompetent performance, and instances of professional misconduct, including but not limited to child abuse, sexual misconduct with patients or surrogates, controlled substance diversion, fraudulent billing, and other disruptive behavior.

All of these categories of information include instances of harm to patients, or circumstances that have a high risk of leading to patient harm. In addition to the oft-cited professional obligation to “do no harm,” physicians also have various responsibilities to patients that fall under the ethical principle of beneficence. These involve promoting the best interests of patients by preventing harm from occurring to them and by removing conditions that will lead to their harm. The duty to report is a fundamental way in which physicians and others can fulfill duties of beneficence by removing potentially harmful conditions.

While responsibilities to report this information to state medical boards and other relevant parties are outlined in state medical practice acts and other legislation, the Federation of State Medical Boards (FSMB) wishes to highlight the importance of reporting relevant information to the state medical boards themselves. In a system that protects the public and that is complaint based, it is imperative that state medical boards have access to the information necessary to fulfill their duties of beneficence. Peers, the public, hospitals, and insurers support the fulfillment of these duties by reporting instances of professional misconduct or incompetence to state medical boards.

In its *Essentials of a State Medical and Osteopathic Practice Act*, the FSMB provides sample language that addresses a wide variety of infractions and the related reporting responsibilities. In addition to physicians’ duties to report any actions against their own licenses or hospital privileges, the *Essentials* outlines duties that reside with other physicians and organizations to report, or cause a report to be made, to the state medical board anytime there is evidence or information that appears to show that a physician is incompetent, guilty of negligence, guilty of a violation of the medical practice act, engaging in inappropriate relationships with patients, is mentally or physically unable to practice safely, or has an alcohol or drug abuse problem. The *Essentials* further states that these same duties exist on the part of hospital or health organization chief executive officers, medical officers, and medical staff. This is in addition to their duty to report to the state medical board any adverse action taken by a health care institution or peer review body.

Despite similar language being included in most states’ medical practice acts, there is evidence that demonstrates that reporting often does not occur. Campbell and colleagues found in a survey

49 of 3504 physicians that while “96% of respondents agreed that physicians should report impaired  
50 or incompetent colleagues to relevant authorities, 45% of respondents who encountered such  
51 colleagues had not reported them.”<sup>1</sup>  
52

53 With respect to institutional reporting, the FSMB has heard complaints from its member boards  
54 that hospitals and health organizations regularly ignore reporting requirements, find ways to  
55 circumvent them, or provide reports that are too brief and general to equip the board with  
56 relevant information for carrying out its regulatory functions. Boards have reported having to  
57 resort to subpoenaing hospital medical directors, threatening disciplinary action to obtain  
58 information, and resorting to civil sanctions. In some instances, failures to report by physicians  
59 and hospitals have resulted in additional avoidable adverse events to patients.  
60

61 An inability to report anonymously in some jurisdictions or health organizations may inhibit  
62 physicians and members of the public from making reports. This may also force physicians who  
63 choose to make reports to take reputational risks and jeopardize interprofessional relations.  
64 While physicians and hospital administrators are encouraged to adhere to the relevant legislation  
65 in their jurisdictions and fulfill their professional duty to report, the ability to make anonymous  
66 complaints and avoid being identified during hearing processes contributes to a culture that  
67 encourages reporting of adverse events and clinical conditions. As such, state medical boards and  
68 hospital administrators should work to ensure that appropriate protections are in place to enable  
69 physicians and patients to complain anonymously. Where allowing anonymous complaints is  
70 impossible or infeasible due to concerns about facilitating the ability to make nefarious,  
71 frivolous, or vexatious complaints, it is essential that complainants’ identities remain confidential  
72 and that licensees who have a complaint before the board be discouraged from attempting to  
73 contact complainants.

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<sup>1</sup> Campbell, EG, et al., *Annals of Int Med* 2007;147(11) 795-802

# **Attachment 3**

## Position of the Federation of State Medical Boards

### Sale of Goods by Physicians and Physician Advertising

#### Sale of Goods by Physicians

Physicians may choose to make health-related and non-health-related goods available to patients from their offices or on their practice websites. This is often in order to meet a legitimate patient need in instances where the goods are medically necessary for patients and not immediately or reliably available to patients by other means.

Physicians who choose to make goods available to patients must be mindful of the inherent power differential that characterizes the physician-patient relationship and therefore the significant potential for exploitation of patients. Physicians must always place the interests of their patients above their own financial interests so that they may avoid conflicts among these interests that could place patient wellbeing at risk. This means only offering treatments or products that can be shown to maintain or enhance their patients' health, in accordance with professional duties of beneficence. Physicians also demonstrate respect for patient autonomy by allowing patients to make their own informed health-related decisions in the absence of any undue influence arising from the substantial degree of trust they have in their physicians.

In order to avoid any perceived or real conflicts of interest, physicians should:

- Make products available at reasonable cost and refrain from excessive mark-ups,
- Ensure that products sold balance benefits to patients with any financial benefit to the physician,
- Provide a disclosure statement with the sale of any goods, informing patients of their financial interests,
- Not engage in exclusive distributorships and/or personal branding, and
- Only offer products that are not otherwise readily available to patients.

An exception exists with respect to non-health-related goods associated with a charitable or service organization (for example, raffle tickets for a local charity or Girls Scout cookies). If physicians choose to make such goods available, they are encouraged to follow the advice of the American Medical Association and ensure that: "(1) the goods in question are low-cost; (2) the physician takes no share in profit from their sale; (3) such sales are not a regular part of the physician's business; (4) sales are conducted in a dignified manner; and (5) sales are conducted in such a way as to assure that patients are not pressured into making purchases."<sup>1</sup>

The principle of non-exploitation of patients also applies to scenarios involving physician-owned pharmacies located in practice offices. In such instances, physicians should offer patients freedom of choice in filling any prescriptions and must therefore allow prescriptions to be filled elsewhere. The existence of such a pharmacy must not influence the physician's clinical judgment in any way and does not change the acceptable standard of care. Further, if medications are prepared and dispensed by physicians and members of their staff, rather than by

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<sup>1</sup> Opinion 8.062 of the American Medical Association, "Sale of Non-Health-Related Goods from Physicians' Offices"

46 licensed pharmacists, patients may not be offered the same safeguards and safety checks that  
47 pharmacists are obligated by law to provide.  
48

49 Physician Advertising  
50

51 Physicians are permitted to advertise themselves, their practice and services offered, provided  
52 that the advertisements do not contain any claims that may be deceptive or are intentionally false  
53 or misleading. Further, physicians should be mindful of ways in which patient testimonials,  
54 quality ratings, or other evaluative data is presented to prospective patients through  
55 advertisements. Such information must be presented in an objective manner and physicians must  
56 not deliberately misrepresent the expected outcomes or results of treatments offered. This also  
57 applies to advertisements about the benefits or efficacy of medical devices sold or rented by  
58 physicians. Physicians should be prepared to support any claims made about benefits of  
59 treatments or devices with documented evidence, for example with studies published in peer-  
60 reviewed publications.  
61

62 Physicians must be accurate and not intentionally misleading in providing descriptions of their  
63 training, skills, or treatments they are able to competently offer to patients. This includes  
64 descriptions of one's specialization and any specialty board certifications. For example, a family  
65 physician who chooses to expand his or her area of practice to offer cosmetic procedures cannot  
66 describe him or herself as a cosmetic or plastic surgeon in advertisements, unless they have  
67 undergone the appropriate postgraduate training to assume the relevant title. As part of the  
68 informed consent process, it is essential that patients are fully informed and not misled about any  
69 treatment to which they are consenting, as well as the qualifications of the person or people  
70 providing it.

# **Attachment 4**

## Position of the Federation of State Medical Boards

### Compounding of Medications by Physicians

Compounding includes the practice of combining or preparing separate ingredients into a single medication for a specific patient. A common example of a compounded drug is an allergy medication that is typically available in pill form, but may be compounded for patients who wish to take it in eye drop or nasal mist form. However, compounding can involve numerous types of preparations, from simple dilution of an approved drug to the production of a drug from bulk drug substance(s) and other ingredients.

Safety concerns exist with compounded drugs, especially those drugs that require a sterile preparation such as injectable drugs, irrigations, or inhalants. If a pathogenic agent is introduced into a drug during the compounding process, it can result in significant patient harm and even death. Further, medications that are compounded incorrectly have the potential to harm patients. It is therefore critical that compounding occur in accordance with conditions and practices to prevent contamination and according to protocols to ensure that ingredients are added in the appropriate proportions.

The decision to compound or prescribe a compounded medication should be in the best interests of the patient. The prescription of a compound and the act of compounding should be triggered by a specific medical need in an individual patient. Physicians should only compound medications for their own patients and not for patients of other physicians or healthcare practitioners. Medications should not be compounded in large quantities in anticipation of patients who exhibit a particular set of symptoms. This could fall under the definition of conventional medication manufacturing, a practice that presents greater safety risks to patients and is therefore restricted to entities that are registered with the U.S. Food and Drug Administration (FDA) and abide by a more stringent set of safeguards for the preparation of medications. However, section 503A of the Federal Food, Drug, and Cosmetic Act (FD&C Act) provides for “anticipatory compounding” by a licensed pharmacist or a licensed physician in limited quantities before receiving a prescription for an identified individual patient. To remain in compliance with federal legislation regarding drug compounding, physicians should not engage in anticipatory compounding beyond such limited quantities.

Physicians must ensure that active ingredients included in a compound are necessary for treating a medical condition in an individual patient. The medical condition and rationale for prescribing a compounded medication should be reflected in the patient’s medical record. Physicians must not add or request the addition of unnecessary substances in order to ensure a higher rate of reimbursement, as this would unnecessarily put patients at greater risk. Physicians must also refrain from charging unreasonable or excessively high fees for compounded medications. This would be considered exploitation of the patient.

In instances where patients require medications in forms that are different from those commercially available, physicians are encouraged to establish relationships with pharmacies or other entities that have registered as outsourcing facilities with the FDA. These facilities are required to compound according to “good manufacturing practices” and are subject to risk-based inspections by the FDA and additional standards that reduce the risk that contamination or other product quality problems might occur during the compounding process.

49 If physicians choose to compound medications themselves, they are encouraged to limit  
50 compounding activity to non-sterile preparations<sup>1</sup> and they must comply with Federal and state  
51 laws regarding compounding and dispensing drugs. While state laws on compounding vary  
52 across the U.S., physicians should comply with the standards set out in the United States  
53 Pharmacopeia-National Formulary (USP-NF), particularly Chapters 795, 797, and 800. Chapters  
54 795 and 797 provide guidance on the preparation of non-sterile and sterile compounds and  
55 describe conditions and practices that can prevent patient harm. Chapter 800 addresses the  
56 compounding and handling of hazardous drugs in healthcare settings. These Chapters of the  
57 USP-NF also describe the responsibilities of supervisors of compounding practices, which may  
58 be relevant for physicians who oversee compounding activities of employed staff.

DRAFT

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<sup>1</sup> Exceptions exist in some medical professions such as Allergy and Immunology where accepted practice regularly includes the preparation of sterile compound by or under the supervision of a specially trained physician for their individual patients. In such instances physicians should follow aseptic technique, as well as the protocols developed by their specialty and set forth in applicable published practice parameters.

**Federation of State Medical Boards  
House of Delegates Meeting  
April 30, 2016**

Subject: Task Force to Study the Need for State Board Regulation of Physician Compounding

Introduced by: North Carolina Medical Board

Approved: January 2016

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**Whereas,** In 2012, a meningitis outbreak resulted from contaminated steroid injections produced at the New England Compounding Center (NECC) in Massachusetts, a compounding pharmacy; and

**Whereas,** In the aftermath of the NECC incident, pharmacy boards around the country increased the level of inspection and regulation of such compounding pharmacists; and

**Whereas,** Historically, physicians have also compounded medications for the use of their patients;

Therefore, be it hereby

**Resolved,** That the Federation of State Medical Boards (FSMB) will establish a task force to review: (1) current federal regulations; (2) the degree to which physicians are currently compounding medicines; and (3) current state laws governing physician compounding; and be it further

**Resolved,** That the FSMB task force will work with the Food and Drug Administration and National Association of Boards of Pharmacy to evaluate the current regulatory environment pertaining to physician compounding; and be it further

**Resolved,** That the FSMB task force will develop recommendations for those states that permit physician compounding.



## FEDERATION OF STATE MEDICAL BOARDS (FSMB)

### Candidates for the FSMB Leadership 2016-2017

#### CHAIR—ELECT

- [Stephen E. Heretick JD - Virginia](#)
- [Gregory B. Snyder, MD - Minnesota](#)

#### BOARD OF DIRECTORS

- [Tariq H. Butt, MD - Illinois](#)
- [Mark A. Eggen, MD - Minnesota](#)
- [Anna Z. Hayden, DO - Florida Osteopathic](#)
- [Ernest E. Miller Jr., DO - West Virginia Osteopathic](#)
- [Kenneth B. Simons, MD - Wisconsin](#)
- [Scott A. Steingard, DO - Arizona Osteopathic](#)
- [Cheryl L. Walker-McGill, MD, MBA - North Carolina](#)
- [Michael D. Zanolli, MD - Tennessee Medical](#)

#### NOMINATING COMMITTEE

- [Jone Geimer-Flanders, DO - Hawaii](#)
- [Stuart F. Mackler, MD - Virginia](#)
- [Carmela Torrelli - New York PMC](#)

#### [Stephen E. Heretick, JD - Virginia](#)

##### **Candidate for Chair-elect (incumbent)**

- FSMB Service: Board of Directors 2012-present; Executive Committee; Governance Committee; Investment Committee; Compensation Committee; Special Committee for Strategic Positioning; Workgroup on Telemedicine
- FSMB Annual Meeting (since 2010): 2010, 2011, 2012, 2013, 2014, 2015
- Member, Virginia Board of Medicine 2003-2014, President 2007-2009
- Member, Virginia General Assembly, representing the 79<sup>th</sup> House District of Virginia
- Director, FSMB Foundation 2009-present, President 2011-2013; Coordinated Public Member Initiative; Coordinated Rights and Distribution of *Responsible Opioid Prescribing, 2<sup>nd</sup> Edition, A Clinician's Guide*; Faculty, 2010 and 2011 FSMB Annual Meetings; Speaker, 2012 Tri-Regulator Conference
- Member, USMLE/NBME Committee on Individualized Review 2014-present
- Member, Portsmouth City Council 2004-2012

- The College of William & Mary, Williamsburg, VA, Bachelor of Arts 1982
- Villanova University Law School, Villanova, PA, Juris Doctor 1988
- Admitted to the Practice of Law Before the Supreme Court of the Commonwealth of Pennsylvania (1988); the Supreme Court of the Commonwealth of Virginia (1989); the United States Courts of Appeals for the Third and Fourth Circuits; the United States District Courts for the Eastern and Western Districts of Virginia, and the Eastern and Middle Districts of Pennsylvania
- Martindale-Hubbell Attorney Rating of "BV-Distinguished"
- Rated as "Qualified" For Appointment as a Judge of the United States District Court for the Eastern District of Virginia by the Virginia State Bar Committee on Judicial Evaluations 2014
- United States Department of Justice Award for Public Service 1992



## PERSONAL STATEMENT

Four years of FSMB service goes by pretty quickly. So does six years on the FSMB Foundation, and eleven years on the Virginia Board of Medicine. Since 2003, it has been my privilege to serve in multiple leadership roles in healthcare regulation with extraordinary physicians and public members, with whom we all share a commitment to providing true excellence in healthcare throughout the world.

Serving on the FSMB Foundation since 2009, and as its President in 2010 - 2013, I worked with physicians and policymakers to help make opiate prescribing safer for patients, their families, and the public. We identified ways to make our boards safer for our Fellows. We utilized talents, skills, and experiences of our public members more effectively. We developed the team that today makes the FSMB Foundation a more robust and proactive resource for the FSMB and our member boards.

Since my election to the FSMB Board of Directors in 2012, and my re-election in 2015, I have served in a broad range of leadership roles on the Executive, Governance and Investment Committees, as well as the Special Committee on Strategic Positioning, among others, all focused on enhancing the FSMB's work as an advocate, resource and partner with our member boards. Visiting with and learning from colleagues across the nation has enhanced my ability to contribute new and innovative policies to the FSMB. I am proud to have had these extraordinary opportunities.

Now, I embrace this opportunity to contribute to the century-long FSMB legacy of leaders who built this organization to stand at the forefront of genuine excellence in medical regulation both nationally and internationally.

I bring an unusual educational background, combining law and health care, combining graduate education at both Villanova University Law School and Hahnemann Medical School. As a former Justice Department lawyer I proudly combine academic, clinical, and research experience with solid experience in law, public policy, litigation, regulatory process and conflict resolution. As the first non-physician President in history of the Virginia Board of Medicine, and now as a member of the Virginia General Assembly, I am honored to use these skills to support meaningful healthcare policy and regulation throughout Virginia.

Public service is central to my life. I value this opportunity to take the next step in FSMB service and leadership. As FSMB Chair-elect, I will remain committed to continue and build upon our proud tradition of advocacy and service to our member boards, and to be your voice for quality healthcare.

I would be honored to serve as your next Chair-elect, and cordially ask for your support.

- [Letter of Nomination](#)
- [Candidate Form](#)
- [Signatory Page](#)
- [CV Summary / Bio](#)
- [Curriculum Vitae](#)

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## [Gregory B. Snyder, MD - Minnesota](#)

Candidate for Chair-elect (incumbent)

- **FSMB Service: Board of Directors 2012-2015, 2015-2018; Chair, Governance Committee 2014, 2015; Audit Committee 2012, 2015; Planning Committee 2013; PLAS Governing Committee 2013-2016; Nominating Committee 2009-2011; Chair, Workgroup on Marijuana and Medical Regulation 2015-2016; Chair, Workgroup on International Collaboration 2014-2015; Chair, Board Liaison Program Task Force 2014-2015; Workgroup on Telemedicine Consultation (SMART II) 2015-2016; State Medical Boards Appropriate Regulation of Telemedicine (SMART) Workgroup 2013-2014; State Board Advisory Panel to USMLE 2013-2014; Telemedicine Workgroup 2010-2012; Attendee, USMLE 7<sup>th</sup> Annual Item Writing Workshop 2012**

- **FSMB Annual Meeting (since 2010): 2010, 2011, 2012, 2013, 2014, 2015**
- **FSMB Liaison Director Current: WI, AK, MN, PR, VI; Former: NV-M, CT, MA, MI-M**
- **FSMB Delegate: FSMB/NABP/NCSBN Tri-regulator Meeting 2012, 2014, 2015; FMRAC 2014; IAMRA 2014**
- **FSMB Liaison: ACEP 2012-2015; ABMS (Alternate) 2013-2014**
- **Minnesota Board of Medical Practice: Member, 2006-2014, President 2014, Vice President 2013; Chair, Complaint Review Committee 2010-2013; Licensing Committee 2006-2010; Voting Delegate to FSMB HOD Meeting 2011**
- **Moderator & Meeting Faculty: “Opioid Prescription Abuse: Forging New Partnerships for Success” Moderator, FSMB Annual Meeting 2015; “Future of Patient Centered Health Care” Panelist, FSMB Annual Meeting 2014; Master of Ceremony, FSMB Investiture of Chair and Delegates 2013; Moderator, Regional Board Meeting 2013, 2014, 2015; Moderator, National Symposium on Telemedicine 2012**



## PERSONAL STATEMENT

To my honorable colleagues in the House of Delegates –

I am grateful for this potential opportunity to continue my service to the Federation as Chair-elect.

Over the past 9 years I have been driven to be as active as possible within the Federation. During this time I have strived to participate as much as possible in each area to which I was appointed, elected or could insert myself in an effort to fully understand the history, work product and relationship of the Federation within the larger house of medicine and more importantly to understand the crucial role that we serve to our member regulatory boards. As I complete my fourth year on the Board of Directors, I feel that I have now developed the requisite skills, institutional knowledge and political savvy to serve as a powerful communicator of the Federation’s message and a strong representative of our values and work products both within our organization and to the wide array of national and international organizations with whom we interact.

Leadership at this level requires a broad understanding of health care in all of its facets. My own journey through medicine includes positions in academics as a university researcher and clinical instructor, Fellowship program director, VA employee, staff physician in a large multi-discipline private practice group and as founder/CEO of two companies in diagnostic radiology and out-patient vascular services. Through these positions I have experienced first-hand the wide variety of challenges and obstacles facing today’s practitioners in a multitude of settings.

Although each state is unique in board composition, staffing, due process and procedures, We ALL share the common bond of responsibility for Patient Safety. The Federation was conceptualized and initiated to promote this common interest and to serve as a solid national resource; for although we continue to seek consensus opinions on key issues of regulation, it remains clear that the best solution to our common challenges ( and to ultimately ensuring Patient Safety) remains with state-based implementation of best practices tailored to the needs and resources available to each individual state.

The Federation remains in a unique position to make lasting contributions to medicine, to support our individual states by supporting all states & territories while shaping the very future of medicine with the core of patient protection and safety at the epicenter.

I am very excited about the opportunity of leadership which lies ahead. Involvement at this level requires a great deal of time and as such, I have recently modified my practice to ensure that I am capable of committing to this responsibility. My personal reward for this endeavor is the vitality and excitement of being allowed to participate in this conversation as collective issues are discussed; analyzed and as functional solutions are developed and promoted.

Unequivocally my involvement with the Federation continues to be the highlight of my medical career and I remain dedicated and prepared to continue my involvement in leadership if graciously allowed to do so by this House of Delegates.

With this in mind, I respectfully submit my application for Chair-elect of The Federation of State Medical Boards.

Most Sincerely,

Gregory B. Snyder, MD DABR

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## [Tariq H. Butt, MD - Illinois](#)

Candidate for Board of Directors

- **FSMB Service: Nominating Committee 2013-2015**
- **FSMB Annual Meeting (since 2010): 2010, 2012, 2013, 2014, 2015**
- Vice President, ACCESS Community Health Network which is the largest health care network of federally-qualified Health Care Centers
- Provide leadership to more than 250 physicians and mid-level providers provide primary, preventive and specialty care to 200,000 adult and pediatric patients throughout the metropolitan Chicago area
- Commitment to medical leadership and influencing health policies to deliver better population based outcomes
- Trustee, Chicago Medical Society; Delegate, Illinois State Medical Society
- Also served as Chair of the Illinois Medical Disciplinary Board and executive physician consultant to the Bureau of Medicaid Integrity
- Mentored hundreds of students throughout the globe and holds teaching appointments at many prestigious academic institutions
- Civic appointment: Chicago Board of Education serving more than 20 years (1995-2011) and also served as director of the Illinois Association of School Boards (1996-2011)



#### PERSONAL STATEMENT

I am a family physician who serves the most challenged patient population and believe in eradicating ethnic health disparities.

Healthcare is changing dramatically and rapidly, and the physicians need to equip themselves with knowledge and applicable information to continue to provide the highest quality of care to their patients. The FSMB has provided a structure to provide physicians an avenue to become lifelong learners and help them to maintain the highest standards when delivering healthcare. The FSMB also provides patients education to stay engaged in participating in their healthcare.

Patient safety and sustaining the highest ethical standards is a delicate balance which the FSMB leadership has done in exemplary ways.

It would be a distinct honor to serve on the Board of Directors and, given the opportunity, I will make every effort to fulfill the mission of the FSMB in ways that make everyone proud. I have experience in various capacities to contribute in humble ways.

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#### [Mark A. Eggen, MD - Minnesota](#)

Candidate for Board of Directors (incumbent)

##### FSMB SERVICE

- Board of Directors 2015-present
- Ethics and Professionalism Committee 2015-present
- Awards Committee 2015-present
- Nominating Committee 2012-2013
- ABMS Health and Public Policy Committee (FSMB Associate)
- Workgroup on Telemedicine Consultation 2014-present
- Workgroup to Define Minimum Data Set (MDS) 2011-2013
- Finance Committee 2011-2012

##### MINNESOTA BOARD OF MEDICAL PRACTICE SERVICE

- President 2015
- Vice President 2014
- Complaint Review Committee Chair 2014
- Complaint Review Committee Member 2011-2013
- Licensure Committee Member 2009-2010, 2016
- Board Member 2009-present



#### PERSONAL STATEMENT

It would be an honor and privilege to continue serving the FSMB as a member of the Board of Directors.

As an FSMB fellow, I have developed a broad, national perspective in medical regulations. My FSMB activities include:

- Board of Directors 2015-present
- Ethics and Professionalism Committee 2015-present
- Awards Committee 2015-present
- Workgroup on Telemedicine Consultations 2014-present
- Nominating Committee 2012-2013
- Minimum Data Set (MDS) Taskforce 2011-present
- Finance Committee 2010
- American Board of Medical Specialties (ABMS) Health and Public Policy Committee 2010-present

I served as a member of the Minnesota Board of Medical Practice for the past six years. On the Minnesota Board, I have served on the Licensure Committee and Complaint Review Committee, including as Chair of a Complaint Review Committee. I have also served as an officer of the Board, including as Board Vice President and, most recently, as Board President.

As a clinician, I was a partner in an anesthesiologist private practice for 20 years, from 1994-2014. In order to serve further in the medical regulatory community, I retired from private practice and joined the University of Minnesota Medical School. I work part-time clinically as an anesthesiologist.

Continuing to serve on the FSMB Board of Directors would give me an opportunity to further the mission, vision and values of the FSMB.

I appreciate your support.

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### [Anna Z. Hayden, DO - Florida Osteopathic](#)

Candidate for Board of Directors

- **FSMB Service: Nominating Committee 2013-2015 included a Joint (w/Bylaws Committee) Taskforce on Nominating Committee Recommendations; Awards Committee 2014-2015; Rules Committee 2015; Workgroup on Education about Medical Regulation 2015 - present; Workgroup on Innovations in State-based Licensure 2012-2014**
- **FSMB Annual Meeting (since 2010): 2011, 2012, 2013, 2014, 2015**
- **Chair, Florida Board of Osteopathic Medicine 2011, 2015**
- **President, American Association of Osteopathic Examiners**
- **Past President, Florida Osteopathic Medical Association**
- **Clinical Professor, [Nova Southeastern University College of Osteopathic Medicine](#)**
- **Director, Medical Education at Broward Health Specialty Care Center**
- **Health Policy Fellow**



### PERSONAL STATEMENT

I am a family medicine practitioner employed by Broward Health working in downtown Fort Lauderdale. I volunteer as clinical professor for Nova Southeastern University College of Osteopathic Medicine training medical students.

I have been active at the community health center serving on medical quality committees to help improve patient safety. At the state level I have served in many leadership roles including Past President of The Florida Osteopathic Medical Association and now current Chair of the Florida Board of Osteopathic Medicine.

In 2009, I completed a health policy fellowship with Ohio University/NYIT where I learned to analyze health policy in terms of cost, assess and quality regarding patient healthcare. Think of unintended consequences and reach for the high ground. To move forward involved getting all the stakeholders together on issues. As I look back on life's challenges I learned how to better analyze things using the health policy fellowship training.

I have been involved with FSMB since getting appointed on my state board in 2010. I have served on the Nominating Committee, the Workgroup on Innovations in State-based Licensure, Workgroup on Education about Medical Regulation, Awards Committee, and also Special Taskforce for the Nominating Committee for Bylaws Review. This experience has given me the opportunity to meet FSMB staff and other fellows. Continuing my involvement to the next level by serving on the board of directors will allow me to continue working with the FSMB to achieve the mission of

improving safe patient care via licensure. I will strive to work diligently on issues facing the FSMB using the perspective and values from the Health Policy Fellowship training and looking at things in a balanced and equitable way.

On a personal note I have been married 27 years with 2 children. My spouse wholeheartedly supports me in my endeavors to run for FSMB BOD.

I humbly ask for your support for a position on the board of directors.

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### [Ernest E. Miller Jr., DO - West Virginia Osteopathic](#)

Candidate for Board of Directors

- **FSMB Service: Voting Delegate (WV-O) 2000-present; Awards Committee 2012-2013, 2013-2014; Nominating Committee 2010-2012; Rules Committee 2013**
- **FSMB Annual Meeting (since 2010): 2010, 2011, 2012, 2013, 2014, 2015**
- **Completed Interstate Medical Licensure Compact; subsequent passage by WV Legislature and signature of the governor of WV**
- **Education of physicians regarding proper pain medication prescriptions and recognizing addiction, dependence and diversion of controlled substances**
- **Modernize Legislation of WV Board of Osteopathic Medicine and rules and regulations**
- **Collaborative legislation and licensure of physician assistants between the Board of Medicine and Osteopathic Medical Board**
- **Advance the Board's ability to license and regulate by implementing electronic initial and renewal licensure as well as reports of completed complaint resolution**
- **Modification of the complaint process to expedite review and final resolution of complaints**
- **Educational processes to medical students and residents regarding responsibilities and rights under licensure as an Osteopathic Physician**
- **Hiring an excellent Executive Director along with having a conscientious hard working board to help in Implementing these accomplishments**



### **PERSONAL STATEMENT**

I am a candidate for the Board of Directors of the FSMB.

My career in medicine, after graduating from the West Virginia School of Osteopathic Medicine and training at the Cuyahoga Falls Hospital, started in Cameron, WV at a public health site and then progressed to my current practice of family medicine in a 19 physician group. At the hospital where I am on staff, I currently chair the Credentials and Medical Peer Review Committees.

My experience in medical licensing started in 1998 to the present on the West Virginia Board of Osteopathy. During this time, I have been a member and I am currently the President of the Board.

Additionally, I have worked on state committees in West Virginia including the DUR for Medicaid. I also am a member of the Medicare Advisory committee to Medicare in West Virginia.

Also, I am Director of Medical Education for an American Osteopathic Internal Medicine Residency Program. I am a Delegate representative to the AOA House of Delegates for West Virginia Osteopathic Medical Association.

In addition I am the Vice President of the medical corporation of Mid Ohio Valley Medical Group Inc.

Because of these experiences I feel I am qualified to serve on the FSMB Board of Directors.

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[Kenneth B. Simons, MD - Wisconsin](#)

Candidate for Board of Directors

- **FSMB Service: Chair, FSMB's State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup 2013-2014; Member, Reference Committee B 2015**
- **FSMB Annual Meeting (since 2010): 2012, 2013, 2014, 2015**
- **Recipient, FSMB Award of Merit 2015**
- **Voting Delegate (WI), FSMB House of Delegates Annual Business Meeting 2014, 2015**
- **Chair, Wisconsin Medical Examining Board July 2013-present, Vice Chair 2013, Member 2011-present**
- **Member, State Medical Boards Advisory Panel to USMLE June 2013-present**
- **Board Member, ACGME 2007-2013**
- **Executive Director, Medical College of Wisconsin of Affiliated Hospitals, Inc.**

**PERSONAL STATEMENT**

I am running for the FSMB Board of Directors as a result of my long-standing interest and dedication to the profession of medicine and its practitioners but in addition, to those for whom it is our privilege to care, our patients. Ensuring that patients receive safe, effective and quality care is fundamental to the Oath we took upon graduation as well as what our medical examining boards require of us.

In my role as Senior Associate Dean for Graduate Medical Education at the Medical College of Wisconsin overseeing 86 ACGME accredited programs with over 850 housestaff, I see on a daily basis how significant a role the clinical learning environment plays in producing caring, compassionate and professional physicians who ultimately must meet the expectations that Medical Examining Boards, as well as society, place upon them. This experience and my commitment to learners, colleagues and patients has prepared me to seek a Board position at this time.

I began my journey in the realm of medical licensure by being appointed to the WI Medical Examining Board in March 2011. Subsequently, I have been elected Chair of the Board three times. I have had service on our credentials and legislative liaison committees, among others. Working with my colleagues and the legislature, we recently were able to develop new classes of license to the benefit of our patients and our physician constituents in terms of patient safety and protection.

Since being appointed to the WI MEB, I have had the pleasure of Chairing the FSMB State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup whose report was unanimously adopted by the FSMB HOD in 2014. In addition, I have and continue to serve on the State Medical Boards Advisory Panel to USMLE and currently Chair the FSMB Workgroup on Telemedicine Consultations.

In addition to my service with the FSMB, I have been fortunate to have served on the ACGME Board of Directors, the NRMP Board of directors and the LCME. All of these broad experiences in medical education and accreditation have provided me with expertise that I believe will translate well to the very important work of the FSMB.

I am excited to run for the FSMB Board of Directors and believe that my skills, prior and current experience coupled with my enthusiasm, energy and collegiality will permit to represent the FSMB well as it continues its critical efforts in medical licensure and public protection.

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[Scott A. Steingard, DO - Arizona Osteopathic](#)

Candidate for Board of Directors

- **Member, FSMB Board of Directors 2010-2013**
- **FSMB Committee/Workgroup Service: Awards 2010-2011, 2011-2012, 2012-2013; Bylaws 2007-2008, 2008-2009; Examine Composite Action Index (CAI) and Board Metrics 2011-2012, 2012-2013, 2013-2014; Finance Sub 2010-2011; Governance 2011-2012, 2012-2013; Impaired Physicians 2010-2011; PLAS Program 2014-2017; Reference 2007; Chair, Reference B 2015; Education about Medical Regulation 2015-2016; Chair, Innovations in State-based Licensure 2012-2013, 2013-2014**
- **FSMB Annual Meeting (since 2010): 2010, 2011, 2012, 2013, 2014, 2015**
- **Member, Arizona Board of Osteopathic Examiners in Medicine & Surgery 1999- 2002, 2006-present**

- **President, Arizona Board of Osteopathic Examiners in Medicine & Surgery 2009-2016**
- **Medical Coordinator, Fiesta Bowl 1988-present**
- **Team Physician for various high school, college and professional organizations**
- **HUGE SPORTS FAN! Baseball, golf, basketball, football**
- **Met my wife during our 1<sup>st</sup> year of medical school; we married in our sophomore year and are the proud parents of three daughters and one son**



#### PERSONAL STATEMENT

I am delighted to seek re-election to the FSMB Board of Directors. I had the honor of serving on the Federation Board from 2010 through 2013. As my term was coming to an end, I made the decision not to seek immediate re-election due to time consuming family obligations that I felt would limit my effectiveness. Although I was not on the Federation Board for the past three years, I have remained active and involved with both Federation and state medical board committees with the anticipation of returning to the board in the future. Both prior to and subsequent to my Board service I have sat on various FSMB committees and workgroups. As my term on the Arizona Osteopathic Board draws to an end, sometime during 2016, I will be able to devote the necessary time to the FSMB Board of Directors.

My background with the FSMB and my years of experience as the Arizona Osteopathic Board President has afforded me practical experience in both governance and leadership. My strengths on the board will be my ability to dissect problems, gain consensus, and help develop creative solutions to the many challenges the Federation faces in health care regulation. During my tenure as President I have led our Board in working with the Legislature, Governor's Office and Osteopathic Association to review and revise our Medical Practice Act Statutes and Rules. We are working toward presenting the Interstate Compact to the Arizona Legislature. The Board and staff are cooperating with the Drug Enforcement Administration and local law enforcement in getting the word out on opioid abuse, including programs for physicians throughout the state of Arizona.

I am active in the community, serving as team physician for both the Fiesta and Cactus Bowls. I developed the "TOPS" Program dedicated to providing free of charge physicals to high school athletes throughout the state of Arizona.

I am a big proponent of the strong role of medical boards in medical regulation, licensure, discipline and protection of the public. I am committed to the mission of the Federation, especially supporting the state Boards. There is a great deal on the horizon; the expansion of the interstate compact, legal issues such as the North Carolina Dental Board and the growth of telemedicine to name a few. I strive to be part of implementing the Federation mission and strategic agenda. I further bring to the table a global vision but at the same time am wise enough to understand our Board's need to interact and coexist on a statewide level. I look forward to continuing my service to the Federation and state Boards as a member of the Federation Board of Directors.

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#### [Cheryl L. Walker-McGill, MD, MBA - North Carolina](#)

Candidate for Board of Directors

- **Regulatory experience with FSMB, including serving on the Bylaws Committee and Workgroup on Team-based Regulation**
- **Attended FSMB Annual Meeting 2012, 2013, 2014, 2015; the 2015 FSMB Tri-Regulator Symposium and served as voting member in the House of Delegates**
- **Four years on NC Medical Board, including serving as the 2015 NCMB Board President and Chair of Discipline and Policy committees**
- **Convened roundtables addressing issues licensees and medical boards face in a changing healthcare environment**
- **Oversaw development of NCMB's 2015-2018 strategic goals, led expansion of outreach initiatives and strengthened oversight of NC Physicians Health Program**



**PERSONAL STATEMENT**

Medicine has changed dramatically since I began my training as a young and naive student at the Duke University School of Medicine, motivated by a simple desire to help people live healthier lives. Medical practice was more straightforward then. Most physicians worked in solo practices or in group settings with the goal of eventual partnership, and providers had almost total autonomy over the care they provided to patients. That made medical regulation simpler as well. When problems arose and a board needed to hold someone accountable, it wasn't difficult to identify the responsible party. Today medicine is infinitely more complex and medical regulation must evolve with it to remain relevant.

As President of the North Carolina Medical Board, I frequently encountered many of the issues facing medical boards across the nation: the corporatization of medicine, transformative changes in healthcare delivery (including the rise of EHR and telemedicine), mounting licensee burnout, and a significant increase in opioid prescribing issues.

Medical boards need support in navigating these historic shifts in the healthcare marketplace. My diverse experience in clinical and academic medicine, medical regulation and business has uniquely prepared me to serve medical boards across the nation. If elected to the Board of Directors, I will pour my experience, focus and energy into promoting best practices and resources to help medical boards and FSMB adapt and continue to serve both the public and licensees. To the role of Director, I bring:

- More than 25 years of experience in clinical medicine, including private practice, corporate healthcare, and academic medicine with a special focus on improving health care delivery in high risk communities;
- Business acumen with experience in strategic planning and quality improvement; led NCMB in developing and implementing the Board's 2015-2018 strategic goals;
- Regulatory experience, including serving on the FSMB Bylaws Committee and Workgroup on Team-based Regulation and four years on the NC Medical Board, serving as Board President as well as Chair of NCMB Discipline, Allied Health and Policy committees;
- Leadership experience, convened NCMB roundtables on burnout and longevity in practice, bringing together diverse perspectives to inform the Board; strengthened NCMB's oversight of the NC Physicians Health Program; addressed a National Governor's Association Policy Academy meeting on responsible opioid prescribing;
- A strong commitment to public service and the desire to help state medical boards perform at the highest level.

Serving on a state medical board has been, and continues to be, one of the best experiences of my career. I would relish the opportunity to serve boards at the national level and believe I am the right choice to help guide FSMB as it stands at the crossroads of American medicine.

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**[Michael D. Zanolli, MD - Tennessee Medical](#)**

Candidate for Board of Directors (incumbent)

- **Professional Academic:** Wake Forest University, Assistant Professor; Vanderbilt University Medical Center, Associate Professor
- **Professional Practice Settings:** University practice; Employed by hospital system; Solo practice (small business owner); Multispecialty practice setting
- **Teaching:** Founding faculty member, Dept of Dermatology of Wake Forest University; Founding faculty member, ACGME approved training program at Wake Forest; Faculty member, Vanderbilt Division of Dermatology
- **Service:** Local, state, national, international organizations with leadership roles at each level; Interaction with physicians from various medical specialties and primary care; Representation of my own specialty and also physicians who practice in my city and state; BME activities; 3 year term on FSMB Board of Directors
- **FSMB Annual Meeting (since 2010):** 2010, 2011, 2012, 2013, 2014, 2015
- **Political:** Submitted resolutions to the TN Medical Association which led directly to state legislative action and new statues regulating the practice of medicine in TN; Chairman for two years of SkinPAC, the federal political action committee of the American Academy of Dermatology; Media training and experience with representation and lobbying of state and U.S. congressman and senators
- **Social:** Spouse of 30 years, Julie Sandine, former Asst Dean for Student Affairs, Vanderbilt University Law School; Fairfax Avenue Bookclub - one of the founding members; 2000 Class A United State Open shotgun shooting FITASC champion

**PERSONAL STATEMENT**

My professional priorities and personal values have inspired me to run for re-election to the FSMB Board of Directors. The motivation to serve another term is driven by my continued responsibility on the Tennessee Board of Medical Examiners and my leadership role as its president. My term over the past three years as an elected Director-at-Large has provided valuable insight into the responsibilities and duties of a member of the FSMB Board of Directors. My work on the FSMB Board has been a significant responsibility, but also a privilege to interact with the leadership of the FSMB and the accomplished executive staff in sharing challenges and initiatives as we have worked to fulfill identified goals.

In 2014 I was fortunate to be a member of the special Strategic Planning Committee and work with others in devising a five-year strategic plan for the FSMB and reaffirming our mission. The product of our work was adopted by the FSMB House of Delegates at the annual meeting in 2015. The FSMB serves as an important voice for state medical boards, while also providing services and initiatives the 70 member boards can use to carry out their duty to promote patient safety through licensure, regulation, and disciplinary actions of licensees. My state board liaison experience as a member of the FSMB Board enables me to better understand the diversity of the membership of the FSMB and nuances of their individual organizational structures. All boards, however, share common goals and the need for access to quality information and resources, which may not be independently available to individual state medical boards. The services and resources of the FSMB can be utilized by member boards at a time that will best enhance their actions and priorities. This scenario is one of the prime examples of how my state board leadership compliments the FSMB Board responsibilities. The FSMB must certainly be aware current challenges and activities of member state medical boards, but must also be proactive in identifying future issues and updating useful information for its membership boards and fellows.

I believe my participation and contribution to the FSMB is not yet complete and I can bring my added experience to new challenges over the next three years. The FSMB should educate, support and facilitate the success of the member boards without being imposing. Continued effort and vigilance will be required to provide access to insightful and accurate information while advocating at the national level for the primary mission of its member boards to protect the safety of the public.

The experience and insights I have gained over the past three years would prove valuable in working toward these important goals, and I would feel honored to have the opportunity to continue playing a role in leading this effort.

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### [Jone Geimer-Flanders, DO - Hawaii](#)

Candidate for Nominating Committee

- **Appointment to the Hawaii Medical Board (2014) was a dream of mine for the past 10 years**
- **I have been doing outreach to Guam, Saipan and American Samoa to help the medical staff of those territories with the quality, risk management and compliance issues since 2010**
- **Award Recipient: Tripler Army Medical Center Residency Teacher of the Year 2010, 2014; Faculty of the Year 2014 (nominated by residents in training and fellow faculty for both awards)**



### PERSONAL STATEMENT

I am a candidate for the Nominating Committee. I started my career in San Antonio, TX where I learned the importance of hard work, compassion for patients and the fierce respect for quality medical care. I was lucky enough to begin my relationship with organized medicine while in medical school serving as the American Medical Student Association and Student Osteopathic Medical Association's president. I have been involved with the Texas Medical Association then Hawaii when we moved to that state and have expanded into the national issues facing the house of medicine along the way.

Currently, I am Chief of Inpatient Medicine at Tripler Army Medical Center and Faculty at University of Hawaii's Medical School. I also serve as the Medical Director for our state's Medicare QIO, working closely with the physicians and hospitals toward compliance. My experiences with quality and risk management began early as I served as a junior physician on committees at the first hospital I worked at, now some 15 years later I have been appointed to our state Medical Board. Physician self-regulation and licensure review has proven to be very rewarding on the board and I look forward to finding ways to expand and enrich the experience. Since being appointed to the Hawaii Medical Board, I have been serving on the legislative committee in a number of capacities, including researching and testimony on pressing legislative issues.

Additionally, I have served on the Board of the American Heart Association, the Hawaii Medical Association as a co-Chair of their Political Action Committee and Alternate Delegate to the AMA.

It is with equal parts of anticipation and respect that I submit my name for consideration. I promise you all the energy, enthusiasm and commitment that this position deserves. My qualifications are broad and strong, which will allow me to function well within a system that is focused on licensure, discipline and protection of the public. I am fully able and devoted to act in accordance to the FSMB's best interests.

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### [Stuart F. Mackler, MD - Virginia](#)

Candidate for Nominating Committee

- **FSMB Service: Bylaws Committee 2015-2016; Education Committee 2014-2015**
- **FSMB Annual Meeting (since 2010): 2014, 2015**
- **Virginia Board of Medicine: Member 2008-present; Vice President 2012-2013; President 2013-2014; Chair of the Nominating, Credentials and Office-based Surgery Committees**
- **Past President, Northampton County Board of Elections**
- **Experience serving on a college presidential search committee**
- **Throughout my career I have been dedicated to maintaining high standards in the practice of medicine**
- **Over 40 years serving in various organizations and on committees tasked to monitor the quality of medical care**



### PERSONAL STATEMENT

I have been focused on the delivery of good medical care for my patients as a practicing physician and surgeon for over 40 years. I was appointed to the Virginia Board of Medicine upon retirement, where I have had the opportunity and privilege to monitor the members of my profession and help ensure that the same standards of care which I strived for would be maintained on a state level. I was introduced to the FSMB as a board member and the amazing role it plays assisting its member boards in maintaining the standard of medical care and improving services rendered to the profession and the public on a national and international level.

I have served in many organizations over my years as a physician and have often served as chairman or president. My earliest participation in the review process came as a member of the armed forces disciplinary review board after my return from service in Vietnam. I served on the presidential search committee, as a member of the board of the Eastern Shore Community College, and was responsible for reviewing over a hundred applications and conducting personal interviews of the finalists. The process was intense and took many weeks to accomplish. I have as a member, officer, and president of the Virginia board, encouraged qualified members to assume positions as officers on the Board and to become involved with the FSMB. I have served on and chaired the nominating committee of the Virginia Board and I am familiar with the duties and responsibilities of the FSMB Nominating Committee.

At the state level there are many aspects of board operation that could be improved and modernized to bring the very best to our licensees and to the public we are sworn to protect. The role the FSMB plays in this is not only important but crucial in assisting the state boards to improve their operation. I would hope that membership on the nominating committee would allow me to participate in the selection of highly motivated and qualified individuals who can lead the organization in this most important work.

I would appreciate your support as I seek a position on the Nominating Committee.

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[Carmela Torrelli - New York PMC](#)

Candidate for Nominating Committee

- FSMB Finance Committee Member 2006-2009
- FSMB Audit Committee Member 2009–present, Chair 2011-2012
- Voting Delegate for NYS BPMC for two of the four years attending FSMB annual meetings
- Vice-Chair, New York State Professional Medical Conduct Board 2009–present
- Member, New York State Professional Medical Conduct Board 1998–present; Board Activity Committee Chair 2010 –present; Board Advisory Committee Co-Chair 2015
- Bank regulator for FDIC with skill sets in forensics, auditing, and staff recruitment

**PERSONAL STATEMENT**

I am a candidate for the FSMB Nominating Committee. I have served as a public member for 17 years on the New York State Board for Professional Medical Conduct with the latter 6 years serving in the capacity of Vice Chair. I feel fortunate to have served as a public member for this length of time and believe in our mission and the importance our Board places in protecting the public, and to say it has been a rewarding and fulfilling experience is an understatement.

In addition, I have been Chair of the NYS Board Activities Committee for the past five years. This Committee is responsible for re-appointments of Board members as we assess the level of commitment and contribution given by each Board member. Additionally, I participate in interviewing many of the new potential Board members and actively question them on their prior experience and their commitment to the role before determining suitability. I also Co-Chair the Advisory Committee and attend monthly Investigative Committee meetings. This commitment and involvement is in addition to fulfilling my fulltime employment position at the Federal Deposit Insurance Corporation (FDIC).

Since 1993 I have worked for the FDIC in the capacity of a financial institution examiner. I currently oversee a team of examiners in my current role as Supervisory Examiner and over the many years have specialized in the area of fraud detection for the banking and investment industry. My skill sets have afforded me the opportunity to be involved in several capacities on various FSMB Committees. I have served on the Finance and Audit Committees, chairing the Audit Committee for one year, and I have attended several FSMB Annual Meetings where I have been the New York State Voting Delegate to the House of Delegates.

My role at the FDIC has evolved as I have also been able to utilize my Human Resources undergraduate minor to assist the Corporation in its hiring efforts. I play a key role in the FDIC's recruiting events both locally and in Washington DC. I serve on a committee that conducts the interviewing and hiring process for potential candidates wanting employment in the area of Risk Management Supervision. I also actively lead the interview and selection process for specialty positions in the New York area.

I believe that my perspective as a public member, my professional expertise in recruitment and placement, my regulatory work experience, and my energy level / skill set will serve the FSMB well. If selected, I will bring the same dedication and commitment to FSMB that I currently bring to the NYS Conduct Board. I fully support the work and direction of this elite organization as it perseveres to protect the public through licensure and regulation. I would be honored at the opportunity to contribute to the ongoing effectiveness and vibrancy of the FSMB's work and mission.

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## **Osteopathic Medicine: Fully Trained and Licensed Physicians Deliver a Comprehensive, Holistic Approach to Patient Care**

There are two kinds of fully trained and licensed physicians practicing medicine in the United States (US). Both Doctors of Osteopathic Medicine (DOs) and Doctors for Medicine (MDs) complete equally rigorous education and training in diagnosis and treatment of illnesses and disorders. Both prescribe medication, perform surgery, and practice in every medical specialty.

Doctors of Osteopathic Medicine come at the practice of medicine from a different philosophy. They focus on prevention by gaining a deeper understanding of a patient's lifestyle and environment, treating the whole person rather than symptoms. DOs receive additional training in Osteopathic Manipulative Treatment (OMT) and use this tool to diagnose, treat and prevent illness or injury.

### **Growth in the Profession**

There are currently 31 colleges of osteopathic medicine educating the next generation of osteopathic physicians at 45 teaching locations across 30 states. With more than 123,000 DOs and osteopathic medical students, osteopathic medicine is currently the fastest growing segment of the health care profession. In addition, one in four U.S. medical students is currently enrolled in an osteopathic medical school.

### **Strength in Primary Care**

Fifty-six percent of DOs in active practice are primary care physicians, helping to mitigate the nation's frontline physician shortage. Primary care includes family, internal and general medicine as well as pediatrics. Among the 44% of DO specialists, the top practice specialties include emergency medicine, obstetrics & gynecology and general surgery.

### **Addressing Health Care Needs**

A disproportionate number of osteopathic physicians provide services in the areas of greatest need when compared to other health care professionals. While DOs make up 11% of all U.S. physicians, they are responsible for 16% of patient visits in communities with populations of fewer than 2,500.<sup>1</sup> Overall, 40% of all physicians that are located in medically underserved areas or who treat medically underserved populations are osteopathic physicians.<sup>2</sup>

### **Equal Recognition and Appropriate Terminology**

The correct term for a Doctor of Osteopathic medicine is osteopathic physician or DO. States vary in their use of "osteopath," "Doctor of Osteopathy" or "Doctor of Osteopathic Medicine" to refer to DOs. U.S.-trained DOs receive complete and comprehensive medical training. Foreign-educated osteopaths have limited training and cannot prescribe medication or perform surgery.

Osteopathic physicians earn a DO degree from a college of osteopathic medicine accredited by the Commission on Osteopathic College Accreditation (COCA), which is granted this authority by the United States Department of Education. They can become fully licensed physicians able to provide all aspects of medical care. Eligibility for licensure requires passage of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) and completion of required postgraduate residency training accredited by either the American Osteopathic Association (AOA)

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<sup>1</sup> Osteopathic Medicine and Medical Education in Brief, American Association of Colleges of Osteopathic Medicine. Available at: <http://www.aacom.org/about/osteomed/Pages/default.aspx>.

<sup>2</sup> 2013 National Center for the Analysis of Healthcare Data (NCAHD)'s Enhanced State Licensure

or Accreditation Council for Graduate Medical Education (ACGME). The COMLEX-USA is recognized by each state licensing board as the tool designed to assess competency in the practice of osteopathic medicine.

The AOA offers primary board certification for DOs in 18 medical specialties. Additionally, the AOA offers certification (Certification of Special Qualifications and Certification of Added Qualification) in various subspecialties. This certification is recognized by state regulators, the American Medical Association (AMA) and Federation of State Medical Boards (FSMB) as being equivalent to member boards of the American Board of Medical Specialties (ABMS).

DRAFT

IN THE GENERAL ASSEMBLY STATE OF \_\_\_\_\_

Osteopathic Medicine Equivalency Act

1 Be it enacted by the People of the State of \_\_\_\_\_, represented in the General Assembly:

2 **Section 1. Title.** This act shall be known as and may be cited as the “Osteopathic Medicine Equivalency  
3 Act.”

4 **Section 2. Purpose.** To ensure adequate access to medical care, and address workforce shortages by  
5 providing universal recognition of osteopathic education, training, certification and practice.

6 **Section 3. Definitions.**

- 7 (a) American Board of Medical Specialties (ABMS) is an organization of approved medical  
8 boards representing 24 areas of specialty medicine. Member boards certify specialists in  
9 over 150 medical specialties and subspecialties.
- 10 (b) American Osteopathic Association (AOA) is the entity that serves as the primary  
11 certifying body for osteopathic physicians and is the accrediting agency for osteopathic  
12 graduate medical education.
- 13 (c) Commission on Osteopathic College Accreditation (COCA), is an independent accrediting  
14 agency recognized by the United States Department of Education to accredit colleges of  
15 osteopathic medicine in the United States.
- 16 (d) Comprehensive Osteopathic Medical Licensure Examination (COMLEX-USA), is the  
17 licensure examination series administered by the National Board of Osteopathic Medical  
18 Examiners (NBOME), and used by all 50 states to demonstrate competency to practice  
19 osteopathic medicine.
- 20 (e) Doctor of Osteopathic Medicine or Osteopathic Physician (DO) means a graduate of a  
21 COCA-accredited college of osteopathic medicine and licensed to practice medicine and  
22 surgery in all its branches as recognized under (drafting note: insert practice act  
23 citation).
- 24 (f) Medical Doctor or Doctor of Medicine (MD) means a graduate of a school of medicine as  
25 recognized in (drafting note: insert practice act citation) and is licensed to practice  
26 medicine and surgery in all its branches as recognized under (drafting note: insert  
27 practice act citation).
- 28 (g) Osteopathic Manipulative Medicine (OMM) means the application of osteopathic  
29 philosophy, structural diagnosis and use of Osteopathic Manipulative Treatment (OMT)  
30 in the diagnosis and management of the patient.

31 (h) Osteopathic Manipulative Treatment (OMT) means the therapeutic application of  
32 manually guided forces by a physician licensed to practice in this state under (drafting  
33 note: insert practice act citation) to improve physiologic function and/or support  
34 homeostasis that has been altered by somatic dysfunction.

35 **Section 4. Requirements.**

36 (a) A person holding a license to practice medicine and surgery as a Doctor of Osteopathic  
37 Medicine shall be authorized to exercise all the same rights, privileges, duties and  
38 responsibilities possessed by Doctors of Medicine.

39 (b) Holders of MD degrees and DO degrees shall be accorded equal professional status and  
40 privileges as licensed physicians and surgeons. Any reference to “medical doctor”, “MD”  
41 or “physician” shall be deemed to include a Doctor of Osteopathic Medicine, DO or an  
42 osteopathic physician, unless any of those terms is specifically excluded.

43 (c) Any entity that requires that the physician be granted or eligible for certification by an  
44 appropriate member board of the American Board of Medical Specialties (ABMS) must  
45 also recognize equally certification by the AOA. In the absence of such recognition, it  
46 shall be construed that ABMS means AOA for osteopathic physicians.

47 (d) Students of colleges of osteopathic medicine and schools of medicine shall be accorded  
48 equal access to state funded training institutions including clinical rotations,  
49 postgraduate residency training programs and fellowships.

50 **Section 5. Effective.** This Act shall become effective immediately upon being enacted into law.

51 **Section 6. Severability.** If any provision of this Act is held by a court to be invalid, such invalidity  
52 shall not affect the remaining provisions of this Act, and to this end the provisions of this  
53 Act are hereby declared severable.