Board of Licensure in Medicine - Board of Osteopathic Licensure
Workgroup
ZOOM meeting
November 19, 2025
5:30 p.m. – 7:03 p.m.

Board Members Present
Christine Munroe, DO (BOL)
Lisa Ryan, DO (BOL)
Melissa Michaud, PA (BOL)
Public Member Peter Michaud, JD, RN (BOL)
Public Member Dennis Smith, Esq. (BOL)
Paul Vinsel, DO (BOL)
John Brewer, DO (BOL)
Renée Fay-LeBlanc, MD (BOLIM)
Public Member Gregory Jamison, RPh (BOLIM)
Noah Nesin, MD (BOLIM) (excused at 6:35 p.m.)
Public Member Lynne Weinstein (BOLIM)
Anthony NG, MD (BOLIM) (arrived at 6:27 p.m.)

Board Staff Present
Rachel MacArthur, Executive Secretary (BOL)
Timothy Terranova, Executive Director (BOLIM)
Paul Smith, MD, Medical Director (BOLIM)
Maureen Lathrop, Administrative Assistant (BOLIM)
Kelly McLaughlin, Complaint Coordinator (BOLIM)

Legal Counsel Present
Lisa Wilson, Assistant Attorney General (BOL)
Jennifer Willis, Assistant Attorney General (BOLIM)

A roll call of board members present was conducted.

Review of Board Discussions and Votes

Dr. Fay-LeBlanc explained that at its November meeting BOLIM unanimously voted in favor of recommending that the Boards merge. However, members expressed various concerns about not wanting to be proscriptive about numbers of MDs or DOs to allow flexibility and to ensure diverse specialty representation. At their November 10 meeting, BOLIM voted 2 in favor and 6 opposed to the proposed composition of members. As an alternative, BOLIM members proposed two options for the physician composition language: (a)The Board shall consist of 12 physician members or (b) The Board shall consist of 12 physician members constituted of at least a minimum number of osteopathic physicians consistent with the proportional numbers of licensed allopathic and osteopathic physicians.

Dr. Nesin added his impression that the BOLIM concerns including allowing for the identification of members to serve on the Board that would be most beneficial to the Board's work rather than a quota of any type of degree and concern that the statute not be limited in that way.

Mr. Smith stated that since the first workgroup meeting in January the discussion has been premised on

the idea that a merged Board would be composed of an equal number of allopathic and osteopathic physicians, initially five of each, which morphed into six of each. The issue of equal representation has been a pillar of the feasibility of a merger from the beginning. Mr. Smith expressed frustration that this was raised at the eleventh hour of this process. Mr. Smith stated that the argument that specialty representation is more important than equal representation can be refuted because BOLIM does not have all specialties. He categorized the concern about specialties as fallacious. He also expressed his impression of BOL's members' feelings of struggling through this process and then having this issue raised 'out of the blue' in November when the report to the Legislative Committee is due in January.

Mr. Michaud added that he did not think this issue was raised in any workgroup meetings with members of both Boards present. He also questioned how to determine which specialties should be included on the Board based on the number of specialties. He further stated that the idea of parity is extremely important because it acknowledges history. He expressed concern that if there is not parity BOL is unlikely to vote in favor of merger.

Mr. Smith stated that the current statutes do not require specific specialty representation on either BOLIM or BOL. The Governor has discretion to appoint members. In the past BOLIM has provided feedback to the Governor's office regarding a particular specialty that would be helpful to the Board in reviewing cases. Mr. Smith stated that the need for diverse specialty representation for the Board to perform its mission is a fallacious argument. He indicated that this is the closest the two Boards have been to proposing a merger. He agreed with Mr. Michaud that unless BOLIM reconsiders its position BOL may not move forward with a recommendation to merge.

Dr. Fay-LeBlanc responded that she understood the concerns and explained that the November BOLIM meeting was the first time BOLIM voted on the language. It was not clear until that time where BOLIM members were on this issue. She also noted that workgroup members tried to communicate discussions from the workgroup meetings and encouraged BOLIM members to participate in workgroup meetings. Dr. Fay-LeBlanc stated that she understands BOL members' frustration and is not happy with where things currently stand.

Mr. Smith indicated that the workgroup materials have been regularly posted on the Boards' website. He stated there is no excuse for last minute alteration. The statute draft has been shared since July. BOL workgroup members have been clear this is a pillar of any merger from a DO perspective. He stated it needs to be clear this is the last moment.

Dr. Nesin indicated that he understands the frustration and concerns that this issue is being raised at the last minute but stated that it is a sincere concern of the majority of BOLIM members about the Board composition and is not motivated by anything else. He also noted that BOLIM workgroup members have worked in good faith and did not anticipate this issue being a concern for BOLIM. He said he does not feel there is currently a distinction drawn in medical practice between allopathic and osteopathic physicians who work side by side as colleagues. He questioned whether a merged board would consist of all of the current members of both boards and if the composition issue could be determined later after trust has been built between Board members.

Mr. Smith thanked Dr. Fay-LeBlanc and Dr. Nesin for acknowledging understanding of BOL members concerns and frustration. He observed that he thinks that BOL will not go forward if this pillar is not there.

Mr. Michaud addressed Dr. Nesin's question about determining Board composition following merger by noting that if the law states that an equal number of allopathic and osteopathic physicians are required

to be appointed to the Board the Governor must follow the law. If the law does not specify equal representation, then there could be a Board consisting of all allopathic or all osteopathic physicians. He also noted that BOLIM's proposed language calls for a percentage of representation based on the percentage of allopathic and osteopathic licensees. He questioned if that meant that the percentage of members would change as the percentage of licensees changed.

Dr. Munroe stated that the discussion at the November BOL meeting was animated with members expressing disappointment and frustration. She added that the basic reason this workgroup came together was to explore feasibility of merging the Boards. The "nitty-gritty" of the discussions occurred in the workgroup meetings. She said it seems like after all the work the workgroup has done they are farther away from merger. She also noted that osteopathic physicians have typically taken on primary care roles. The number of osteopathic physicians is fewer in the specialty areas. She echoed other BOL members' concern that without parity BOL will not vote in favor of merger.

Dr. Brewer said that this vote "takes us back 30 years, the way osteopaths and allopaths were at loggerheads for 30 years."

Dr. Vinsel noted that he graduated from the University of New England in 1984. He could not do clinical rotations at Maine Medical Center or Eastern Maine Medical Center because the education committees at those hospitals would not allow osteopathic physicians. He left Maine in 1984 and returned in 2017 and was amazed at the change of allopathic and osteopathic colleagues working together. He agreed that equal representation is a pillar of BOL supporting a merger. He indicated that he had informed DOs that equal representation would occur in the merger and stuck his head out to state that to other DOs and it turns out they were right about equal representation not being included. Knowing the history of the disparities in the two professions, Dr. Vinsel indicated that if there were two boards a DO could appear in front of and one was 6 DOs, 4 public members, and 2 PAs, and the other was 6 MDs and 2 DOs, 4 pubic members and 2 PAs, he knew which Board he would want to face. The answer is clearly the DO Board.

Dr. Brewer said Dr. Vinsel expressed the concerns well. When the BOLIM vote was shared with BOL at the November meeting, BOL members were "thunderstruck" and felt as though "the rug had been pulled out from under us." He said that BOL members could not understand why alternate language was being proposed at the eleventh hour. He said that BOL members have offered reassurance to the MOA, AOA and osteopathic community throughout this process that there was good faith on both sides and discussions were entered into in good faith. He reiterated comments from other BOL members that parity is key. He agreed that diversity is a great thing, but equal representation is more important. The groups work well together, however when it comes to licensing, without parity he can't feel comfortable. As to the specialists, there are a lot more specialist MDs and favoring this would be more uneven. DOs have legitimate fears. He stated that he cannot voice how disappointed he was and that BOL was thunderstruck.

Mr. Terranova shared comments from Gust Stringos, DO (BOL Board member) who was unable to attend the workgroup meeting. Dr. Stringos believes the proposed Board composition should remain six allopathic physicians and six osteopathic physicians and without that agreement he will not support merger.

Dr. Fay-LeBlanc asked in light of the fact that some BOLIM members' feedback is the concern about specialty representation and questioned whether there is a way to have parity and include language providing for specialty representation. Both Boards think merger is a good idea, is there a way to move forward?

Mr. Michaud indicated that this specialist issue has not been developed well in the process and asked how specialties would be picked, because you can't end up with a true cross-section. He indicated parity is a pillar of the proposed merger.

Dr. Nesin indicated that the workgroup members from BOLIM were working in good faith and that they did not anticipate the majority vote. He also described his initial experience when first practicing in another region where he saw DOs and MDs working without distinction, in the 1980s. This marked the beginning of the shift to the current state where there isn't a distinction in practice anymore, which he indicated drove BOLIM's positions regarding more full potential pool of board members. He also noted that his assumption was that the transition would involve all existing Board members from each Board being seated on the new board to steer the transition process and trust would be built and processes handled together.

Dr. Munroe indicated DOs traditionally practice primary care in rural areas and that automatically decreases DO membership if specialist focused, which she said was not a small thing.

Mr. Michaud said the minimum would become the de facto number serving DOs based on human and political nature. He indicated that continuing to treat a minority as a minority risks discrimination. He also stated that parity was based in recognition of physicians of both stripes working together.

Mr. Smith indicated that the focus on specialties was unnecessary because the current statute doesn't provide for that. Historically, the Board has provided feedback regarding specialties and has conveyed that to the Governor through the ED and Board members. He underlined that the diverse need for medical specialties fallacious. Outside expert reviews are always done. Starting with parity would do more to promote and protect unity. Parity is more than just a symbol. Maybe 20-25 years or 10 years from now there'd be more development, and maybe then parity wouldn't be so important, but now parity is key. Putting together actual statutory language, we've never been this close.

Mr. Michaud expressed that he has the utmost respect for all people participating on the workgroup and noted that they have worked well together. He questioned where the specialty concern is coming from and asked how many cases involve questions of specialty. He believes most BOL complaints involve matters such as boundary issues, sexual misconduct, and professionalism. He stated the parity issue overcomes the specialty issue.

Ms. Weinstein noted that having specialists on the board is helpful for many cases, but it is not a make-or-break situation. The Boards can request outside expert review of any matter that requires specialty input. She is concerned that the workgroup had come so far in discussions and now seems to be back to where they started.

Dr. Ryan echoed that she was very disheartened when she learned that BOLIM voted to move forward with merger, but Board composition was not a unanimous decision. She said from the BOL perspective many members have participated in the workgroup and it has been a very thoughtful process which they have taken very seriously. She thinks the BOL would come to a unanimous decision, but if there is no parity the decision will likely not be a recommendation to merge.

Review of Proposed Statute

Workgroup members agreed that review of the proposed statute was not necessary at this time.

Next Steps

Mr. Terranova said that the workgroup discussion was valuable and the information will be shared with BOLIM at the next meeting on December 9th. Mr. Michaud asked if there would be interest in having a representative of BOL attend the BOLIM meeting. Ms. Weinstein, Dr. Ng and Mr. Jamison all agreed that having a BOL member attend the next BOLIM meeting to discuss concerns may be helpful. Dr. Fay-LeBlanc expressed concern that she did not want to put any BOL member in an uncomfortable situation. Dr. Nesin said he thinks it would be helpful to have an osteopathic colleague come to the BOLIM meeting and explain their perspective of having experienced discrimination in the past and the concerns of the osteopathic community regarding parity.

Dr. Ryan suggested that Mr. Smith and one of the physician members attend the BOLIM meeting. Mr. Smith and Dr. Brewer agreed to attend the BOLIM meeting on December 9th. Mr. Terranova suggested an 8:30 a.m. meeting time which was agreed upon.

Public Comment

Mr. Terranova shared that written comments were received from the MOA and the AOA. Written comments were provided to the workgroup.

Robert Piccinini, DO: Dr. Piccinini noted that he is a psychiatrist and President of AOA. He appreciates the ongoing opportunity to offer comments. The AOA continues to advocate for a conservative approach to address BOL staffing concerns. In addition, Dr. Piccinini raised concerns that BOLIM licenses international medical graduates and that if LD105 passes and the boards merge, resources that could be used for DOs would be used in implementing a program that does not benefit DOs.

Kathryn Brandt, DO: Dr. Brandt thanked workgroup members for their efforts, and Mr. Smith and Dr. Brewer for volunteering to attend the next BOLIM meeting. She said that great progress has been made, but she is concerned that the vote from BOLIM reveals that not enough progress has been made to move forward with a merger.

Jodi Hermann, DO: Dr. Hermann said that it has been a privilege to sit in at the workgroup meetings and hear the discussions. She was extremely disappointed to hear the outcome of the BOLIM vote. It disheartens her and she wonders if there are trust issues. She stated that we don't want to march backward to move forward, and osteopathic physicians are concerned about their profession.

Next meeting is December 17th at 5:30 p.m.

Adjourn 7:03

Board of Licensure in Medicine/Board of Osteopathic Licensure Workgroup
161 Capitol Street
Augusta, Maine 04333-0137
November 19, 2025
5:30 pm

The November 19, 2025 meeting of the workgroup is being held with workgroup members participating virtually on Zoom. There will be an opportunity for the public to view the meeting at the Board's offices in Augusta. A link for the public to access the meeting virtually is included below and posted on the Board's website. **The Board encourages members of the public to attend the meeting virtually.**

Join Zoom Meeting https://mainestate.zoom.us/j/81280177996

Meeting ID: 812 8017 7996 **Passcode**: 91799893 or by phone (312) 626-6799 or 1 (646) 876-9923

I. Role Call of Board Members
II. Review of Board Discussions and Votes
III. Review of Proposed Statute – see page 4 for alternative BOLIM language in the notes
IV. Next Steps
V. Public Comment
    A. Written Comment
        i. MOA
        ii. AOA
VI. Adjourn

DRAFT STATUTE FOR COMBINED MEDICAL BOARD PREPARED BY DENNIS SMITH, ESQ

CHAPTER XXX

PART A

MAINE MEDICAL BOARD

SUBCHAPTER 1

GENERAL PROVISIONS

§XXXX. Short title

This chapter may be known and cited as "the Maine Board of Medicine Medical Practice Act."

§XXXX. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. **Allopathic Physician. "Allopathic Physician" means a physician who graduated from medical school with an MD degree.**
2. **Board.** "Board" means the Maine Board of Medicine established in Title 5, section 12004-A, subsection X.
3. **Collaborative Agreement** "Collaborative agreement" means a document agreed to by a physician associate and a physician that describes the scope of practice for the physician assistant as determined by practice setting and describes the decision-making process for a health care team, including communication and consultation among health care team members.
4. **Consultation** "Consultation" means engagement in a process in which members of a health care team use their complementary training, skill, knowledge and experience to provide the best care for a patient.
5. **Health Care Team** "Health care team" means 2 or more health care professionals working in a coordinated, complementary and agreed-upon manner to provide quality, cost-effective, evidence-based care to a patient and may include a physician, physician assistant, advanced practice nurse, nurse, physical therapist, occupational therapist, speech therapist, social worker, nutritionist, psychotherapist, counselor or other licensed professional.
6. **License.** "License" means a license, certificate, certification, registration, permit, approval or other similar document issued by the Board to qualified individuals granting authority to engage in the practice of medicine.
7. **Osteopathic Physician.** "Osteopathic Physician" means a physician who graduated from medical school with a DO degree.
8. **Physician.** "Physician" means an allopathic or osteopathic physician or surgeon licensed by the Board.
9. **Physician Associate.** "Physician Associate" means a physician associate licensed by the Board.
10. **Practice Agreement** "Practice agreement" means a document agreed to by a physician assistant who is the principal clinical provider in a practice and a physician that states the physician will be available to the physician assistant for collaboration or consultation.
11. **Practice of Medicine.** "Practice of Medicine" means diagnosing, relieving in any degree or curing, or professing or attempting to diagnose, relieve or cure a human disease, ailment, defect or complaint, whether physical or mental, or of physical and mental origin, by attendance, by surgery,

Commented [TT1]: This is slightly different than 3270 Unless licensed by the board, an individual may not practice medicine or surgery or a branch of medicine or surgery or claim to be legally licensed to practice medicine or surgery or a branch of medicine or surgery within the State by diagnosing, relieving in any degree or curing, or professing or attempting to diagnose, relieve or cure a human disease, ailment, defect or complaint, whether physical or mental, or of physical and mental origin, by attendance or by advice, or by prescribing or furnishing a drug, medicine, appliance, manipulation, method or a therapeutic agent whatsoever or in any other manner unless otherwise provided by statutes of this State.

or by advice, or by prescribing or furnishing a drug, medicine, appliance, manipulation, method or a therapeutic agent and includes:

- **A.** Advertising, holding out to the public, or representing in any manner that one is authorized to practice medicine in Maine;
- **B.** Offering or undertaking to prescribe, order, give, or administer any drug or medicine for use by any other person;
- **C.** Offering or undertaking to prevent or to diagnose, correct, and/or treat in any manner or by any means, methods, or devices any disease, illness, pain, wound, fracture, infirmity, defect, or abnormal physical or mental condition of any person;
- **D.** Offering or undertaking to perform any surgical operation upon any person;
- **E.** Rendering a written or otherwise documented medical opinion concerning the diagnosis or treatment of a patient or the actual rendering of treatment to a patient within a state by a physician located outside the state as a result of transmission of individual patient data by electronic or other means from within a state to such physician or the physician's agent;
- **F.** Rendering a determination of medical necessity or a decision affecting the diagnosis and/or treatment of a patient; and
- **G.** Using the designation Doctor, Doctor of Medicine, Doctor of Osteopathic Medicine/Doctor of Osteopathy, Physician, Surgeon, Physician and Surgeon, Dr., M.D., D.O., or any combination thereof in the conduct of any occupation or profession pertaining to the prevention, diagnosis, or treatment of human disease or condition unless such a designation additionally contains the description of another branch of the healing arts for which one holds a valid license in the jurisdiction where the patient is located.
- **H.** Maintaining adequate medical records pursuant to the standard of care.

12. **Prescription or Legend Drug** "Prescription or legend drug" has the same meaning as "prescription drug" in section 13702-A, subsection 30 and includes schedule II to schedule V drugs or other substances regulated under the federal Controlled Substances Act, 21 United States Code, Section 812.
13. **Render Medical Services** "Render medical services" means the rendering of health care services for the diagnosis, prevention, treatment, cure or relief of a health condition, injury or disease.
    - **A.** Advertising, holding out to the public, or representing in any manner that one is authorized to render medical services in Maine;
    - **B.** Offering or undertaking to prescribe, order, give, or administer any drug or medicine for use by any other person;
    - **C.** Offering or undertaking to prevent or to diagnose, correct, and/or treat in any manner or by any means, methods, or devices any disease, illness, pain, wound, fracture, infirmity, defect, or abnormal physical or mental condition of any person;
    - **D.** Offering or undertaking to perform any surgical operation upon any person;
    - **E.** Rendering a written or otherwise documented medical opinion concerning the diagnosis or treatment of a patient or the actual rendering of treatment to a patient within a state by a physician associate located outside the state as a result of transmission of individual patient data by electronic or other means from within a state to such physician or the physician associate's agent;
    - **F.** Rendering a determination of medical necessity or a decision affecting the diagnosis and/or treatment of a patient; and
    - **G.** Using the designation Physician Associate, Physician Assistant or PA., or any combination thereof in the conduct of any occupation or profession pertaining to the prevention, diagnosis, or treatment of human disease or condition in the jurisdiction where the patient is located.
    - **H.** Maintaining adequate medical records pursuant to the standard of care.

§XXXX. Individual license

Only an individual may be licensed or privileged by the Board and only an individual licensed or privileged by the Board may practice medicine or render medical services to patients in Maine, unless exempted in statutory provision.

§XXXX. License required

1. **Unlicensed practice.**
   A. A person may not engage in the practice of medicine without a license or during any period when that person's license has expired or has been suspended, surrendered, or revoked.
   B. A person may not render medical services as a physician associate without a license or privilege from the Board, and may not render medical services during any period when that person's license or privilege has expired, been suspended, surrendered, or revoked.
2. **Penalties.** A person who violates this section may be subject to action pursuant to Title 10 section 80003-C.

§XXXX. Exemption for licensed or privileged person accompanying visiting athletic team

1. **Licensed or privileged person accompanying visiting athletic team.** This chapter does not apply to a person who holds a current unrestricted license to practice medicine and surgery in another state when the person, pursuant to a written agreement with an athletic team located in the state in which the person holds the license, provides medical services to any of the following while the team is traveling to or from or participating in a sporting event in this State:
   A. A member of the athletic team;
   B. A member of the athletic team's coaching, communications, equipment or sports medicine staff;
   C. A member of a band or cheerleading squad accompanying the team;
   D. The team's mascot.
2. **Restrictions.** A person authorized to provide medical services in this State pursuant to subsection 1 may not provide medical services at a health care facility, including a hospital, ambulatory surgical facility or any other facility where medical care, diagnosis or treatment is provided on an inpatient or outpatient basis.

SUBCHAPTER 2

MAINE BOARD OF MEDICINE

§XXXX. Board creation; declaration of policy; compensation

1. Board creation; declaration of policy. The Maine Board of Medicine, as established in Title 5, section 12004-A, subsection X, is created within this subchapter. The board recognizes the unique philosophical and educational differences between allopathic physicians, osteopathic physicians, and physician associates. This legislation, and the board, does not intend to combine these into one profession. The purpose of this legislation is to protect the people of Maine by efficiently setting licensing standards for the three separate professions with one licensing board.

§XXXX. Board membership

1. **Membership; terms; removal.** The board consists of 20 members appointed by the Governor as follows:
   A. Six allopathic physicians. Each physician member must hold a valid license under this chapter and must have been in the clinical practice of medicine in this State for a continuous period of five (5) years immediately preceding appointment.

B. Six osteopathic physicians. Each physician member must hold a valid license under this chapter and must have been in the clinical practice of medicine in this State for a continuous period of five (5) years immediately preceding appointment.

C. Four physician associates. Each physician associate must hold a valid license under this chapter and must have been in the clinical rendering of medical services in this State for a continuous period of five (5) years immediately preceding appointment.

D. Four public members. The public members must be residents of this State and must have no financial interest in the medical profession and have never been licensed, certified or given a permit in this or any other state to practice medicine.

The Governor may accept nominations from professional associations and from other organizations and individuals. A member of the board must be a legal resident of the State. A person who has been disciplined by a medical regulatory body in any jurisdiction or who has been convicted of a crime that is related to the practice of medicine or the rendering of medical services or which is punishable by more than one year's imprisonment, is not eligible for appointment to the board. Appointment of members must comply with Title 10, section 8009.

2. **Terms.** Terms of the members of the board are for 5 years. A person who has served 10 years or more on the board is not eligible for re-appointment to the board. A board member may be removed by the Governor for cause.
3. **Quorum.**
   A. General business, rulemaking, policies, guidelines, legislation. A majority of the members of the board constitutes a quorum for the transaction of official general business, rulemaking, policy making, guidelines, and legislation.
   B. Adjudicatory hearings. Five members of the board constitute a quorum for the conduct of adjudicatory hearings pursuant to this chapter.
4. **Meetings.** The board shall hold a minimum of two regular meetings a year and any additional special meetings at a time and place the chair may designate.
5. **Board Officers**. The members of the board shall meet on the 2nd Tuesday of July of the uneven-numbered years at the time and place the board may determine and shall elect a chair, vice-chair and a secretary who shall hold their respective offices for the term of 2 years. The secretary of the board shall perform such duties as delegated by the board through rule.

The board through its executive director shall receive all fees, charges and assessments payable to the board and account for and pay over the same according to law. The board shall hold regular meetings at times and places as it may determine. The board shall cause a seal to be engraved and shall keep a record of all their proceedings.

6. **Compensation.** Members of the board shall be compensated according to the provisions of Title 5, chapter 379. If the fees to be collected under any of the provisions of this chapter are insufficient to pay the salaries and expenses provided by this section, the members of the board shall be entitled to only a pro rata payment for salary in any years in which such fees are insufficient.
7. **Oath.** Each member of the board shall, before entering upon the duties of the member's office, take the constitutional oath of office.

§XXXX. Powers and duties of the board

The board has the following powers and duties in addition to all other powers and duties imposed by this chapter:

1. **Set standards.** The power to set standards of eligibility for examination for candidates desiring admission to medical practice in Maine;
2. **Adopt criteria.** The power to design or adopt an examination and other suitable criteria for establishing a candidate's knowledge in medicine and its related skills;

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The Board shall consist of 12 physician members. or
The Board shall consist of 12 physician members constituted of at least a minimum number of osteopathic physicians consistent with the proportional numbers of licensed allopathic and osteopathic physicians.

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3. **Licensing and standards.** The power to license and to set standards of practice for physicians and surgeons practicing medicine in Maine;
4. **Hearings and procedure.** The power to conduct adjudicatory hearings, the authority to administer oaths, compel the testimony of witnesses and compel the production of books, records and documents relevant to inquiry pursuant to a subpoena and take evidence in all matters relating to the exercise and performance of the powers and duties vested in the board;
5. **Subpoena authority.** The power to issue subpoenas in accordance with the terms of Title 5, section 9060, for the production of documents, records and the testimony of witnesses except that the authority applies to any stage of an investigation and is not limited to an adjudicatory proceeding, and during investigation this power is delegated to the Executive Director, or in the Executive Director's absence by the Assistant Executive Director;
6. **Legal representation.** The power to engage legal counsel, to be approved by the Attorney General, and investigative assistants of its own choosing to advise the board generally and specifically, to represent the board in hearings before it and in appeals taken from a decision of the board;
7. **Salary and duties.** Except as provided in subsections 15 and 16, the power to employ and prescribe the duties of other personnel as the board determines necessary. Except as prescribed in subsection 15, the appointment and compensation of that staff is subject to the Civil Service Law;
8. **Rules.** The power to adopt rules as the board determines necessary and proper to carry out this chapter. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A;
9. **Complaints.** The duty to investigate complaints in a timely fashion on its own motion and those filed with the board regarding the potential violation of a section of this chapter and the violation of rules adopted by the board pursuant to its authority;
10. **Investigations.** The duty to open investigations following receipt of reports required by law to be filed with the board or other information and reports made to the board regarding a licensee or applicant for licensure.
11. **Report.** By March 1st of each year, the board shall submit to the Legislature a report consisting of statistics on the following for the preceding year:
    A. The number of complaints against licensees received from the public or filed on the board's own motion;
    B. The number of complaints dismissed for lack of merit or insufficient evidence of grounds for discipline;
    C. The number of cases in process of investigation or hearing carried over at year end; and
    D. The number of disciplinary actions finalized during the report year.
12. **Open financial records.** The duty to keep a record of the names and residences of all individuals licensed under this chapter and a record of all money received and disbursed by the board, and records or duplicates must always be open to inspection in the office of the secretary during regular office hours. The board shall annually make a report to the Commissioner of Professional and Financial Regulation and to the Legislature containing a full and complete account of all its official acts during the preceding year, and a statement of its receipts and disbursements and comments or suggestions as the board determines essential;
13. **Medical Education Contract Powers.** The power to mandate, conduct and operate or contract with other agencies, individuals, firms or associations for the conduct and operation of programs of medical education, including statewide programs of health education for the general public and to disburse funds accumulated through the receipt of licensure fees for this purpose, provided that funds may not be disbursed for this purpose for out-of-state travel, meals or lodging for a physician being educated under this program. The power to conduct and operate or contract with other agencies or nonprofit organizations for the conduct and operation

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of a program of financial assistance to medical students indicating an intent to engage in family practice in rural Maine, under which program the students may be provided with interest-free grants or interest-bearing loans in an amount not to exceed $5,000 per student per year on terms and conditions as the board may determine.

14. **Conduct Examinations**. The power to conduct examinations relevant to licensure.
15. **Other services and functions.** The power to provide services and carry out functions necessary to fulfill the board's statutory responsibilities. The board may set reasonable fees for services such as providing license certification and verifications, providing copies of board law and rules, and providing copies of documents. The board may also set reasonable fees to defray its cost in administering examinations for special purposes that it may from time to time require and for admitting courtesy candidates from other states to its examinations;
16. **Budget.** The duty to submit to the Commissioner of Professional and Financial Regulation its budgetary requirements in the same manner as is provided in Title 5, section 1665, and the commissioner shall in turn transmit these requirements to the Bureau of the Budget without revision, alteration or change, unless alterations are mutually agreed upon by the department and the board or the board's designee;
17. **Adequacy of budget, fees and staffing.** The duty to ensure that the budget submitted by the board to the Commissioner of Professional and Financial Regulation is sufficient, if approved, to provide for adequate legal and investigative personnel on the board's staff and that of the Attorney General to ensure that professional liability complaints described in Title 24, section 2607 and complaints regarding a section of this chapter can be resolved in a timely fashion. The board's staff must include one position staffed by an individual who is primarily a consumer assistant. Within the limit set by this chapter, the board shall charge sufficient licensure fees to finance this budget provision. The board shall submit legislation to request an increase in these fees should they prove inadequate to the provisions of this subsection.

    Within the limit of funds provided to it by the board, the Department of the Attorney General shall make available to the board sufficient legal and investigative staff to enable all consumer complaints mentioned in this subsection to be resolved in a timely fashion;

18. **Executive director.** The power to appoint an executive director who serves at the pleasure of the board and who shall assist the board in carrying out its administrative duties and responsibilities under this chapter. The salary range for the executive director must be set by the board within the range established by Title 2, section 6-C;
19. **Approval of licenses.** The power to direct staff to review and approve applications for licensure or renewal in accordance with criteria established in law or in rules adopted by the board. Licensing decisions made by staff may be appealed to the full board;
20. **Protocols for professional review committee.** The authority to establish protocols for the operation of a professional review committee as defined in Title 24, section 2502, subsection 4-A. The protocols must include the committee reporting information the board considers appropriate regarding reports received, contracts or investigations made and the disposition of each report, as long as the committee is not required to disclose any personally identifiable information. The protocols may not prohibit an impaired licensee under this chapter from seeking alternative forms of treatment;
21. **Authority to order a mental or physical examination.** The board or one of its investigative committees has the power to direct that a licensee or applicant for licensure or re-licensure undergo a mental and/or physical examination by a physician or other person. An individual examined pursuant to the direction of the committee may not prevent the testimony of the examining individual or prevent the acceptance into evidence of the report of an examining individual in any proceeding before the committee or board.
22. **Assessment of costs.** When there is a finding of a violation, the power to assess the licensee for all or part of the actual expenses incurred by the board or its agents for investigations and

enforcement duties performed. For the purposes of this subsection, "actual expenses" includes, but is not limited to, travel expenses and the proportionate part of the salaries and other expenses of investigators or inspectors, hourly costs of hearing officers, costs associated with record retrieval and the costs of transcribing or reproducing the administrative record.

23. **Special license categories.** The board may issue a license limited to the practice of administrative medicine, or any other special license, as defined by routine technical rule of the board adopted pursuant to Title 5, chapter 375, subchapter 2-A.

Commented [TT6]: Already in law 10 MRS 8003-D, with additional timeframes permitted for assessment of costs:
§8003-D. Investigations; enforcement duties; assessments
When there is a finding of a violation, a board affiliated with the department identified in section 8001-A may assess the licensed person or entity for all or part of the actual expenses incurred by the board or its agents for investigations and enforcement duties performed. [PL 2011, c. 286, Pt. B, §4 (AMD).]
"Actual expenses" include, but are not limited to, travel expenses and the proportionate part of the salaries and other expenses of investigators or inspectors, hourly costs of hearing officers, costs associated with record retrieval and the costs of transcribing or reproducing the administrative record. [PL 1999, c. 687, Pt. C, §12 (NEW).]
The board, as soon as feasible after finding a violation, shall give the licensee notice of the assessment. The licensee shall pay the assessment in the time specified by the board, which may not be less than 30 days.

§XXXX Role of the Commissioner

The Commissioner of Professional and Financial Regulation acts as a liaison between the board and the Governor.

The Commissioner of Professional and Financial Regulation does not have the authority to exercise or interfere with the exercise of discretionary, regulatory or licensing authority granted by statute to the board. The commissioner may require the board to be accessible to the public for complaints and questions during regular business hours and to provide any information the commissioner requires in order to ensure that the board is operating administratively within the requirements of this chapter.

§XXXX. Inspection or copying of record; procedure

1. Request for record; redaction. When the board receives a request to inspect or copy all or part of the record of an applicant or licensee, the board shall redact information that is not public before making the record available for inspection or copying.
2. Notice and opportunity to review. When the board acknowledges a request to inspect or copy an applicant's or a licensee's record as required by Title 1, section 408-A, subsection 3, the board shall send a notice to the applicant or licensee at the applicant's or licensee's last address on file with the board explaining that the request has been made and that the applicant or licensee may review the redacted record before it is made available for inspection or copying. The acknowledgment to the requester must include a description of the review process provided to the applicant or licensee pursuant to this section, including the fact that all or part of the record may be withheld if the board finds that disclosure of all or part of the redacted record creates a potential risk to the applicant's or licensee's Generated 01.07.2025 Chapter 48. BOARD OF LICENSURE IN MEDICINE | 31MRS Title 32, Chapter 48. BOARD OF LICENSURE IN MEDICINE personal safety or the personal safety of any 3rd party. The applicant or licensee has 10 business days from the date the board sends the notice to request the opportunity to review the redacted record. If the applicant or licensee so requests, the board shall send a copy of the redacted record to the applicant or licensee for review. The board shall make the redacted record available to the requester for inspection or copying 10 business days after sending the redacted record to the applicant or licensee for review unless the board receives a petition from the applicant or licensee under subsection 4. [PL 2019, c. 499, §3 (NEW).]
3. Reasonable costs. Reasonable costs related to the review of a record by the applicant or licensee are considered part of the board's costs to make the redacted record available for inspection or copying under subsection 2 and may be charged to the requester. [PL 2019, c. 499, §3 (NEW).]
4. Action based on personal safety. An applicant or licensee may petition the board to withhold the release of all or part of a record under subsection 2 based on the potential risk to the applicant's or licensee's personal safety or the personal safety of any 3rd party if the record is disclosed to the public. The applicant or licensee must petition the board to withhold all or part of the record within 10 business days after the board sends the applicant or licensee the redacted record. The petition must include an explanation of the potential safety risks and a list of items requested to be withheld. Within 60 days of receiving the petition, the board shall notify the applicant or licensee of its

decision on the petition. If the applicant or licensee disagrees with the board's decision, the applicant or licensee may file a petition in Superior Court to enjoin the release of the record under subsection 5. [PL 2019, c. 499, §3 (NEW).]

5. Injunction based on personal safety. An applicant or licensee may bring an action in Superior Court to enjoin the board from releasing all or part of a record under subsection 2 based on the potential risk to the applicant's or licensee's personal safety or the personal safety of any 3rd party if the record is disclosed to the public. The applicant or licensee must file the action within 10 business days after the board notifies the applicant or licensee under subsection 4 that the board will release all or part of the redacted record to the requester. The applicant or licensee shall immediately provide written notice to the board that the action has been filed, and the board may not make the record available for inspection or copying until the action is resolved. [PL 2019, c. 499, §3 (NEW).]
6. Hearing. The hearing on an action filed under subsection 5 may be advanced on the docket and receive priority over other cases when the court determines that the interests of justice so require. [PL 2019, c. 499, §3 (NEW).]
7. Application. This section does not apply to requests for records from other governmental licensing or disciplinary authorities or from any health care providers located within or outside this State that are concerned with granting, limiting or denying an applicant's or licensee's employment or privileges.

SUBCHAPTER 3

LICENSURE

§XXXX. Individual license

Only an individual may be licensed under this chapter and only a licensed individual may provide services for which a license is required under this chapter.

§XXXX. Licensure or privilege required

1. **Unlicensed practice.**
   - **A.** Unless licensed or privileged by the board, an individual may not practice medicine or render medical services to any patient located in Maine. A person shall not engage in the practice of medicine or render medical services without a license or during any period when that person's license is in inactive status, has expired, or has been suspended, surrendered, or revoked.
   - **B.** Any individual who practices medicine, renders medical services, or holds themselves out as doing so, when they hold no valid, active license or privilege to do so, may be subject to disciplinary action by the board, or legal action by the Department of the Attorney General under 10 M.R.S. § 8003-C.
2. **Penalties.** A person who violates this section commits a Class E crime. Violation of this section is a strict liability crime as defined in Title 17-A, section 34, subsection 4-A.

§XXXX. Exemption for licensed person accompanying visiting athletic team

1. **Licensed person accompanying visiting athletic team.** This chapter does not apply to a person who holds a current unrestricted license to practice medicine and surgery in another state when the person, pursuant to a written agreement with an athletic team located in the state in which the person holds the license, provides medical services to any of the following while the team is traveling to or from or participating in a sporting event in this State:
   - **A.** A member of the athletic team;

B. A member of the athletic team's coaching, communications, equipment or sports medicine staff;

C. A member of a band or cheerleading squad accompanying the team;

D. The team's mascot.

2. **Restrictions.** A person authorized to provide medical services in this State pursuant to subsection 1 may not provide medical services at a health care facility, including a hospital, ambulatory surgical facility or any other facility where medical care, diagnosis or treatment is provided on an inpatient or outpatient basis.

§XXXX. Application; fees; general requirements

1. **Application.** An applicant seeking a license from the board must submit an administratively complete application, licensure or application fee(s) established by rule adopted by the board and any other materials required by the board.
2. **Fees.** All fees set in this chapter are nonrefundable application fees or administrative processing fees payable to the board at the time of application or at the time board action is requested. The board shall establish by rule the fees for each license issued by the board. The maximum fees for each license issued by the board are enumerated within this subchapter.
3. **Confidentiality of personal contact and health information.** A personal residence address, personal telephone number or personal e-mail address submitted to the board as part of any application under this chapter is confidential and may not be disclosed except as permitted under this section or as otherwise required by law unless the applicant who submitted the information has indicated that the applicant is willing to have the applicant's personal residence address, personal telephone number or personal e-mail address treated as a public record. Personal health information submitted to the board as part of any application under this chapter is confidential and may not be disclosed except as otherwise permitted under this section or otherwise required by law.

   The board and its staff may disclose personal health information about and the personal residence address and personal email or telephone number of a licensee or an applicant for a license under this chapter to a government licensing or disciplinary authority or to a health care provider located within or outside this State that are concerned with granting, limiting or denying a license or employment or privileges to the applicant or licensee.
4. **Public contact information required.** An applicant or licensee shall provide the board with a current professional address and telephone number, which will be their public contact address. An applicant or licensee who does not have a public contact address and phone number must use their personal address and phone number as the public contact information.
5. **Consent to physical or mental examination; objections to admissibility of examiner's testimony waived.** For the purposes of this section, every physician and physician associate licensed or privileged by the board who accepts the privilege of practicing medicine or rendering medical services in this State by the filing of an application and of biannual registration renewal:
   A. Is deemed to have consented to a mental or physical examination by a physician or other person selected or approved by the board when directed in writing by the board or investigative committee; and
   B. Is deemed to have waived all objections to the admissibility of the examining physician's or other person's testimony or reports on the ground that these constitute a privileged communication.

   Pursuant to Title 4, section 184, subsection 6, the District Court shall immediately suspend the license of a physician or physician associate who can be shown, through the results of the medical or physical examination conducted under this section or through other competent evidence, to be unable to render medical services with reasonable skill and safety to patients by reason of mental

Commented [TT7]: Should this apply to info provided in a complaint?

illness, alcohol intemperance, excessive use of drugs or narcotics or as a result of a mental or physical condition interfering with the competent provision of medical services.

6. **Licenses must be displayed.** Each physician or physician associate licensed under this chapter is entitled to receive a license under the seal of the board and signed by the chair and the secretary, which must be publicly displayed at the individual's principal place of practice, as long as this individual continues the practice of medicine.

§XXXX-A. Licensure of physician associates

1. **Qualification for licensure.** The board may issue to an individual a license to practice as a physician associate under the following conditions:
   - **A.** A license may be issued to an individual who:
     1. Graduated from a physician assistant/associate program approved by the board;
     2. Passed a physician assistant/associate national certifying examination administered by the National Commission on Certification of Physician Assistants or its successor organization;
     3. Demonstrates current clinical competency either by having engaged in the clinical rendering of medical services during the preceding 24 months, or by providing a plan to practically demonstrate to the Board's satisfaction their clinical competency, the requirements of which may be set by rulemaking;
     4. Does not have a license, certificate of registration or privilege that is the subject of disciplinary action such as probation, restriction, suspension, revocation or surrender;
     5. Completes an application approved by the board;
     6. Pays an application fee of up to $400; and
     7. Passes an examination approved by the board; and
   - **B.** No grounds exist as set forth in section XXXX (Grounds for Discipline) to deny the application.
2. **Rules.** The board is authorized to adopt rules regarding the licensure and practice of physician associates. These rules may pertain to, but are not limited to, the following matters:
   - **A.** Information to be contained in the application for a license;
   - **B.** Education requirements for the physician associate;
   - **C.** Requirements for collaborative agreements and practice agreements, including uniform standards and forms;
   - **D.** Requirements for a physician associate to notify the board regarding certain circumstances, including but not limited to any change in address, the permanent departure of the physician associate from the State, any criminal convictions of the physician associate and any discipline by other jurisdictions of the physician associate;
   - **E.** Issuance of temporary physician associate licenses;
   - **F.** Continuing education requirements as a precondition to continued licensure or licensure renewal;
   - **G.** Fees for the application for an initial physician associate license, which may not exceed $400; and
   - **H.** Fees for the biennial renewal of a physician associate license in an amount not to exceed $350.
3. **Privileging of Physician Associates**
   - **A.** The board will issue a privilege to a physician associate as permitted under Title 32 chapter XX (PA Compact statute).
   - **B.** The application fee to obtain a privilege through the P.A. Compact shall be no higher than the application fee for a physician associate license.
   - **C.** Fees for the renewal of a physician associate Compact privilege shall not to exceed $350.

Commented [TT8]: Need a discussion on raising the cap on all fees. They don't need to be raised now, but to plan for the future.

§XXXX-B. Physician associate criminal history record information; fees

Criminal history record information; fees

1. Background check. The board shall request a background check for each person who submits an application for initial licensure or licensure by endorsement as a physician associates under this chapter. The board shall request a background check for each licensed physician assistant who applies for an initial compact privilege and designates this State as the applicant's participating state in accordance with chapter 145-A. The background check must include criminal history record information obtained from the Maine Criminal Justice Information System, established in Title 16, section 631, and the Federal Bureau of Investigation.

A. The criminal history record information obtained from the Maine Criminal Justice Information System must include public criminal history record information as defined in Title 16, section 703, subsection 8.

B. The criminal history record information obtained from the Federal Bureau of Investigation must include other state and national criminal history record information.

C. An applicant or licensee shall submit to having fingerprints taken. The Department of Public Safety, Bureau of State Police, upon payment by the applicant or licensee of a fee established by the board, shall take or cause to be taken the applicant's or licensee's fingerprints and shall forward the fingerprints to the Department of Public Safety, Bureau of State Police, State Bureau of Identification so that the State Bureau of Identification can conduct state and national criminal history record checks. Except for the portion of the payment, if any, that constitutes the processing fee charged by the Federal Bureau of Investigation, all money received by the Bureau of State Police for purposes of this paragraph must be paid to the Treasurer of State. The money must be applied to the expenses of administration incurred by the Department of Public Safety. Any person who fails to transmit criminal fingerprint records to the State Bureau of Identification pursuant to this paragraph is subject to the provisions of Title 25, section 1550.

D. The subject of a Federal Bureau of Investigation criminal history record check may obtain a copy of the criminal history record check by following the procedures outlined in 28 Code of Federal Regulations, Sections 16.32 and 16.33. The subject of a state criminal history record check may inspect and review the criminal history record information pursuant to Title 16, section 709.

E. State and federal criminal history record information of an applicant for a physician assistant license may be used by the board for the purpose of screening the applicant. State and federal criminal history record information of a licensed physician assistant seeking an initial compact privilege may be used by the board for the purpose of taking disciplinary action against the licensee. A board action against an applicant for licensure or a licensee under this subsection is subject to the provisions of Title 5, chapter 341.

F. Information obtained pursuant to this subsection is confidential. The results of background checks received by the board are for official use only and may not be disseminated to the Physician Assistants Licensure Compact Commission established under section 18537 or to any other person. G. An individual whose license has expired and who has not applied for renewal may request in writing that the Department of Public Safety, Bureau of State Police, State Bureau of Identification remove the individual's fingerprints from the bureau's fingerprint file. In response to a written request, the bureau shall remove the individual's fingerprints from the fingerprint file and provide written confirmation of that removal. 2. Rules. The board, following consultation with the Department of Public Safety, Bureau of State Police, State Bureau of Identification, may adopt rules to implement this section.

Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A**.**

§XXXX. Qualification for licensure as allopathic physicians

Except where otherwise specified by this chapter, all applicants for licensure as an allopathic physician or surgeon in the State must satisfy the following requirements.

1. **Medical education.** Each applicant must:
   - **A.** Graduate from a medical school designated as accredited by the Liaison Committee on Medical Education or the Committee on Accreditation of Canadian Medical Schools;
   - **B.** Graduate from an unaccredited medical school, be evaluated by the Educational Commission for Foreign Medical Graduates and hold a current certificate from the Educational Commission for Foreign Graduates; or
   - **C.** Graduate from an unaccredited medical school and achieve a passing score on a comprehensive examination determined by the board to be substantially equivalent to the United States Medical Licensing Examination (USMLE) or other examinations designated by the board as the qualifying examination or examinations for licensure.
2. **Postgraduate training.** Each applicant who has graduated from an accredited medical school on or after January 1, 1970 but before July 1, 2004 must have satisfactorily completed at least 24 months in a graduate educational program accredited by the Accreditation Council on Graduate Medical Education, the Canadian Medical Association or the Royal College of Physicians and Surgeons of Canada. Notwithstanding other requirements of postgraduate training, an applicant is eligible for licensure when the candidate has satisfactorily graduated from a combined postgraduate training program in which each of the contributing programs is accredited by the Accreditation Council on Graduate Medical Education and the applicant is eligible for accreditation by the American Board of Medical Specialties in both specialties. Each applicant who has graduated from an accredited medical school prior to January 1, 1970 must have satisfactorily completed at least 12 months in a graduate educational program accredited by the Accreditation Council on Graduate Medical Education, the Canadian Medical Association or the Royal College of Physicians and Surgeons of Canada. Each applicant who has graduated from an accredited medical school on or after July 1, 2004 or an unaccredited medical school must have satisfactorily completed at least 36 months in a graduate educational program accredited by the Accreditation Council on Graduate Medical Education, the Canadian Medical Association, the Royal College of Physicians and Surgeons of Canada or the Royal Colleges of England, Ireland or Scotland. An applicant who has completed 24 months of postgraduate training and has received an unrestricted endorsement from the director of an accredited graduate education program in the State is considered to have satisfied the postgraduate training requirements of this subsection if the applicant continues in that program and completes 36 months of postgraduate training. Notwithstanding this subsection, an applicant who is board certified by the American Board of Medical Specialties is deemed to meet the postgraduate training requirements of this subsection. Notwithstanding this subsection, in the case of subspecialty or clinical fellowship programs, the board may accept in fulfillment of the requirements of this subsection postgraduate training at a hospital in which the subspecialty clinical program, such as a training program accredited by the American Dental Association Commission on Dental Accreditation or its successor organization, is not accredited but the parent specialty program is accredited by the Accreditation Council on Graduate Medical Education, including training that occurs following graduation from a dental school accredited by the American Dental Association Commission on Dental Accreditation or its successor organization, but before graduation from a medical school accredited by the Liaison Committee on Medical Education or its successor organization.

Commented [TT9]: THE LCME stopped accrediting Canadian schools on 6/301/25. We need to discuss how to proceed with Canadian students.

Commented [TT10]: Obtaining this information is often a confusing and time consuming process. Is there a better way? Such as, Applicants who have graduated, trained and are licensed and registered in either England Scotland, Ireland or Canada are deemed to have meet the Medical Education, Postgraduate training and Examination requirements.

3. **Current clinical competency**. The physician has engaged in active clinical practice in the previous 24 months, or has provided a plan to practically demonstrate to the Board's satisfaction their clinical competency, the requirements of which may be set by rulemaking.
4. **National board certification not required.** The board may not require an applicant for initial licensure or license renewal as a physician under this chapter to obtain certification from a specialty medical board or to obtain a maintenance of certification as a condition of licensure. For the purposes of this subsection, "maintenance of certification" means a program that requires a physician to engage in periodic examination, self-assessment, peer evaluation or other activities to maintain certification from a specialty medical board.
5. **Examination.** Each applicant must achieve a passing score on each component of the uniform examination of the Federation of State Medical Boards or other examinations designated by the board as the qualifying examination or examinations for licensure. Each applicant must additionally achieve a passing score on a State of Maine examination administered by the board.
6. **Fees.** Each applicant shall pay a fee up to $700 plus the cost of the qualifying examination or examinations.
7. **Board action.** An applicant may not be licensed unless the board finds that the applicant is qualified and no cause exists, as set forth in section 3282-A, that may be considered grounds for disciplinary action against a licensed physician or surgeon.
8. **Waiver for exceptional circumstances.** The board may waive the requirements of subsection 2 for a physician who does not meet the postgraduate training requirements but who meets the requirements of this subsection.
    - **A.** To be considered for a waiver under this subsection, the physician must:
        1. Be a graduate of a foreign medical school, not including a medical school in Canada or Great Britain;
        2. Be licensed in another state; and
        3. Have at least 3 years of clinical experience in the area of expertise.
    - **B.** If the physician meets the requirements of paragraph A, the board shall use the following qualifications of the physician to determine whether to grant a waiver:
        1. Completion of a 3-year clinical fellowship in the United States in the area of expertise. The burden of proof as to the quality and content of the fellowship is placed on the applicant;
        2. Appointment to a clinical academic position at a licensed medical school in the United States;
        3. Publication in peer-reviewed clinical medical journals recognized by the board;
        4. The number of years in clinical practice; and
        5. Other criteria demonstrating expertise, such as awards or other recognition.
    - **C.** The costs associated with the board's determination of licensing eligibility in regard to paragraph B may be assessed for payment by the applicant upon completion of the determination under paragraph A. The application cost must reflect and not exceed the actual cost of the final determination.

Commented [TT11]: Needs to be updated

§XXXX. Qualification for licensure as osteopathic physicians

Except where otherwise specified by this chapter, all applicants for licensure as an osteopathic physician or surgeon in the State must satisfy the following requirements.

1. **Osteopathic education.** An applicant must graduate from an osteopathic medical school designated as accredited by the American Osteopathic Association's Commission on Osteopathic College Accreditation.
2. **Postgraduate training.** An applicant who has graduated from an accredited osteopathic medical school prior to January 1, 2026 must have satisfactorily completed at least 12 months in a medical graduate educational program accredited by the Accreditation Council on Graduate Medical

Education or the American Osteopathic Association. An applicant who has graduated from an accredited osteopathic medical school on or after January 1, 2026 must have satisfactorily completed at least 36 months in a graduate educational program accredited by the Accreditation Council on Graduate Medical Education or the American Osteopathic Association.

The board may not require an applicant for initial licensure or license renewal as an osteopathic physician under this chapter to obtain certification from a specialty medical board or to complete maintenance of certification as a condition of licensure. For the purposes of this subsection, "maintenance of certification" means a program that requires a physician to engage in periodic examination, self-assessment, peer evaluation or other activities to maintain certification from a specialty medical board.

3. **Current clinical competency**. The physician has engaged in active clinical practice in the previous 24 months, or has provided a plan to practically demonstrate to the Board's satisfaction their clinical competency, the requirements of which may be set by rulemaking.
4. **Examination.** An applicant must achieve a passing score on each component of the National Board of Osteopathic Medical Examiners' Comprehensive Osteopathic Medical Licensing Examination of the United States, known as the COMLEX-USA examination, or other examinations designated by the board as the qualifying examination or examinations for licensure.
5. **Fees.** An applicant must pay a fee up to $700 plus the cost of the qualifying examination or examinations. Fees set in this chapter are nonrefundable application fees or administrative processing fees payable to the board at the time of application or at the time board action is requested.
6. **No cause for disciplinary action.** An applicant may not be licensed unless the board finds that the applicant is qualified and no cause exists, as set forth in section 2591-A, that may be considered grounds for disciplinary action against a licensed physician.

§XXXX. Background check for expedited physician licensure through the Interstate Medical Licensure Compact

1. Background check. The board shall request a background check for an individual licensed under this chapter who applies for an expedited license under section 18506. The background check must include criminal history record information obtained from the Maine Criminal Justice Information System and the Federal Bureau of Investigation.

A. The criminal history record information obtained from the Maine Criminal Justice Information System must include a record of public criminal history record information as defined in Title 16, section 703, subsection 8.

B. The criminal history record information obtained from the Federal Bureau of Investigation must include other state and national criminal history record information.

C. An applicant shall submit to having fingerprints taken. The State Police, upon payment by the applicant, shall take or cause to be taken the applicant's fingerprints and shall forward the fingerprints to the State Bureau of Identification so that the bureau can conduct state and national criminal history record checks. Except for the portion of the payment, if any, that constitutes the processing fee charged by the Federal Bureau of Investigation, all money received by the State Police for purposes of this paragraph must be paid over to the Treasurer of State. The money must be applied to the expenses of administration incurred by the Department of Public Safety.

D. The subject of a Federal Bureau of Investigation criminal history record check may obtain a copy of the criminal history record check by following the procedures outlined in 28 Code of Federal Regulations, Sections 16.32 and 16.33. The subject of a state criminal history record check may inspect and review the criminal history record information pursuant to Title 16, section 709.

E. State and federal criminal history record information of an applicant may be used by the board for the purpose of screening that applicant

F. Information obtained pursuant to this subsection is confidential. The results of background checks received by the board are for official use only and may not be disseminated to the Interstate Medical Licensure Compact Commission, established in section 18512, or to any other person or entity.

G. An individual whose expedited licensure through the Interstate Medical Licensure Compact under chapter 145 has expired and who has not applied for renewal may request in writing that the State Bureau of Identification remove the individual's fingerprints from the bureau's fingerprint file. In response to a written request, the bureau shall remove the individual's fingerprints from the fingerprint file and provide written confirmation of that removal.

2. Rules. The board, following consultation with the State Bureau of Identification, shall adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

§XXXX. Other physician license types.

1. Temporary licensure

A physician who is qualified under section XXXX may, without examination, be granted a temporary license for a period not to exceed one year when the board determines that this action is necessary in order to provide relief for local or national emergencies or for situations in which the number of physicians is insufficient to supply adequate medical services or for the purpose of permitting the physician to serve as locum tenens for another physician who is licensed to practice medicine in this State. The fee for this temporary license may not be more than $400.

2. Youth camp physicians

A physician who is qualified under section XXXX may, at the discretion of the board, be temporarily licensed as a youth camp physician so that the physician may care for the campers in that particular youth camp licensed under Title 22, section 2495 for which the physician was hired and retained as a youth camp physician. That physician is entitled to practice only on patients in the youth camp. The temporary license must be obtained each year. Application for this temporary license must be made in the same form and manner as for regular licensure. An examination may not be exacted from applicants for these temporary licenses. The fee for temporary licensure may not be more than $400 annually.

3. Emergency 100-day license

A physician who presents a current active unconditioned license from another United States licensing jurisdiction and who can provide reasonable proof of meeting qualifications for licensure in this State must be issued a license to serve temporarily for declared emergencies in the State or for other appropriate reasons as determined by the board. The license is effective for not more than 100 days. The fee for this license may be not more than $400.

4. Temporary Educational Certificate

A. Residents. An applicant who is qualified under section XXXX may receive a temporary educational certificate from the board to act as a hospital resident. A certificate to a hospital resident may be renewed every 3 years at the discretion of the board for not more than 8 years.

B. Joint-program resident. An applicant who is enrolled in a program of medical and graduate medical training conducted jointly by a medical school accredited by the Liaison Committee on Medical Education and a graduate medical education program approved by the Accreditation Council on Graduate Medical Education may receive a temporary

educational certificate from the board to act as a hospital resident as part of that graduate medical education program if the applicant is concurrently enrolled in the final year of medical training and the initial year of graduate medical education. The board may not issue a certificate pursuant to this subsection for a period longer than that required to obtain the M.D. degree. The period during which the certificate is in force may not be considered in determining satisfaction of the requirement for postgraduate medical education under section XXXX.

C. Conditions for Temporary Educational Certificate. An applicant for a temporary educational certificate may not be certified unless the board finds that the applicant is qualified and that there exists no cause, as set forth in section XXXX, that would be considered grounds for disciplinary action against a licensed physician or surgeon. The board, in its discretion, may require an examination for applicants for temporary educational certificates. Recipients of these certificates are entitled to all the rights granted to physicians who are licensed to practice medicine and surgery, except that their practice is limited to the training programs in which they are enrolled. A temporary educational certificate may be suspended or revoked, or the board may refuse to renew the certificate, for the reasons stated in section XXXX, or if the resident has violated the limitations placed upon the temporary educational certificate. The fee for this license may be not more than $300.

5. Visiting instructors. A physician who has an unrestricted license to practice medicine or surgery in another state may practice medicine or surgery in this State when the physician is performing medical procedures as part of a course of instruction in graduate medical education in a hospital located in this State. The right of a visiting medical instructor to practice medicine in this State may be suspended or revoked for the reasons stated in section XXXX, or if the visiting medical instructor has performed medical procedures that are not a part of a course of instruction. The fee for this license may be not more than $300.

§XXXX. Biennial renewal of physician and physician associate licenses; qualification; fees; reinstatement after lapse

1. Renewal of licenses. Except as otherwise provided in this chapter, a physician or physician associate with a license issued by the board, including IMLC licenses, shall apply to the board for relicensure using application forms and submitting supporting documents required by the board. Except as provided in paragraph A for initial proration of expiration dates, the board shall provide to every licensee whose renewal application is approved and accepted proof of license renewal that is valid for no longer than 2 years.

A. Regardless of the date of initial licensure or last license renewal, the license of every physician and physician associate born in an odd-numbered year expires at midnight on the last day of the month of the individual's birth in every odd-numbered year. The license of every physician and physician associate born in an even-numbered year expires at midnight on the last day of the month of the individual's birth in every even numbered year. Prior to expiration, a physician or physician associate must renew the license issued pursuant to this section by means of application to the board, on forms prescribed and supplied by the board.

B. At least 60 days prior to expiration of a current license, the board shall notify each licensee of the requirement to renew the license. If an administratively complete license renewal application, as determined pursuant to subsection X, paragraph X, has not been submitted prior to the expiration date of the existing license, the license immediately and automatically expires. A license may be reinstated within 90 days after the date of expiration upon submission of an administratively complete application, and payment of the renewal fee and late fee. If an administratively complete renewal application is not submitted within 90 days of the date of the expiration of the license, the license

immediately and automatically lapses. The board may reinstate a license that has lapsed pursuant to subsection 4.

2. **Criteria for license renewal.** Prior to renewing a license:
   - **A.** The board may pose any question to the licensee or other sources that the board determines appropriate related to qualification for relicensure. These matters may include, but are not limited to, confirmation of health status, professional standing and conduct, professional liability claims history and license status in other jurisdictions. The board shall, after affording the licensee due process, deny license renewal if the board finds cause that may be considered grounds for refusal to renew the license pursuant to section XXXX, including, but not limited to, a determination that an outstanding financial obligation to the board exists; and
   - **B.** Every licensee seeking renewal of a license with the intent of conducting active clinical medical practice or rendering medical services in this State shall submit evidence, satisfactory to the board, of successful completion of a course of continuing medical education within the preceding 24 months, as prescribed by rule. A licensee may not engage in the clinical practice of medicine or render medical services in this State in any degree, unless the board has found the licensee qualified by continuing medical education and has marked the current license with the designation "active
3. **Fees.** The following fees apply to licensure.
   - **A.** The board may charge a license renewal application fee of not more than $600 to all applicants for full license renewal.
   - **B.** In addition to the application processing fee, the board may require payment of a late application fee of not more than $100 from all licensees, regardless of age, from whom the board has not received an administratively complete license renewal application prior to the license expiration date. An application is not administratively complete if it is not signed and dated by the licensee or does not provide full information and responses of sufficient detail to permit board review, evaluation and decision on renewal qualification. An application received without the required license renewal application fee is considered incomplete and the applicant is subject to a late fee.
   - **C.** The board may prorate the fee for biennial relicensure for individuals who have been issued a full license within the past 12 months. The manner of proration, if done, must be explained in the board's published schedule of fees. The board may waive all or a portion of the established license renewal application fee upon receipt of a request for waiver based on hardship or other special circumstance. Any waiver request granted and the basis for the waiver must be recorded in the minutes of the board's proceedings.
   - **D.** Unless received and deposited to the board's account in error and in violation of this section or the board's rules, a license renewal application fee or late fee paid to the board is not refundable if the board or the board's staff has commenced processing the application, regardless of the board's action on the application.
4. **Reinstatement after lapse.** A license may be reinstated after the lapse of a license under the following conditions.
   - **A.** A license that has lapsed pursuant to subsection X, paragraph X may be reinstated upon application by the individual on forms provided by the board. An individual whose license has lapsed for more than 5 years shall apply for a new license.
   - **B.** When applying for reinstatement, the licensee must state the reason why the license lapsed and pay all fees in arrears at the time of lapse plus the current license renewal application fee and a nonrefundable reinstatement application processing fee of $100
   - **C.** The board may not reinstate a lapsed full license if the board finds any cause that may be considered a ground for discipline pursuant to section XXX if the license had been in force. Prior to concluding that no cause exists, the board shall conduct the inquiries required by

subsection X, paragraph X for applications for renewal. In addition, the board may not reinstate the license of any individual who has not provided evidence satisfactory to the board of having actively engaged in the clinical practice of medicine or rendering of medical services during the past 24 months under the license of another jurisdiction of the United States or Canada unless the applicant has first satisfied the board of the applicant's current clinical competency by providing a plan to practically demonstrate to the Board's satisfaction their clinical competency, the requirements of which may be set through rulemaking.

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§XXXX. Withdrawal of license

A licensee who notifies the board in writing of the withdrawal of the individual's license is not required to pay licensure fees or penalties beyond those due at the time of the holder's withdrawal, but after a holder gives this notice, the holder's license to practice is not valid until reinstated by the board.

Commented [TT13]: Existing statute S. 3281 has an additional paragraph
An applicant for reinstatement is entitled to be reinstated upon paying a reinstatement fee of $50 and satisfying the board that the applicant has paid all fees and penalties due at the time of the applicant's withdrawal, and no cause exists for revoking or suspending the applicant's license, and the applicant has applied within 5 years after the applicant's withdrawal, and was in active practice outside this State within one year prior to the filing of application for reinstatement.

§XXXX. Inactive license status

A licensee who wants to retain licensure while not practicing or rendering medical services may apply for an inactive status license. During inactive status, the licensee must renew the license and pay the renewal fee set by rule. Inactive status licensees shall not engage in the clinical practice of medicine or shall not engage in the clinical rendering of medical services. Continuing medical education hours and the jurisprudence examination are not required for inactive status licensees unless they seek reinstatement or conversion to active status.

SUBCHAPTER 4
COMPLAINTS AND INVESTIGATIONS

§XXXX. Investigative Committee. Separate investigative committees are established within the board with the power and authority to conduct and act upon investigations in accordance with this subchapter.

1. **Composition.** The chair of the board shall divide the membership of the board into two (2) investigative committees of ten (10) members, each investigative committee to include 3 allopathic physicians, 3 osteopathic physicians, 2 physician associates and 2 public members. The investigative committees shall be chaired by the elected Chair or Vice-Chair serving on that committee, and each investigative committee may choose an alternate to chair individual meetings in the absence of the Chair or Vice-Chair. Each investigative committee shall have the power to act as an investigative committee or a hearing panel.
2. **Powers and duties of an investigative committee**. An investigative committee of the board has the following powers and duties:
   A. The duty to investigate complaints, mandated reports, other reports and licensing matters in a timely fashion regarding potential violation of a section of this chapter and the violation of rules adopted by the board pursuant to its authority.
   B. The power to issue subpoenas for the productions of documents and records;
   C. The power to direct that a licensee or applicant for licensure or re-licensure undergo a mental and/or physical examination by a physician or other person. An individual examined pursuant to the direction of the committee may not prevent the testimony of the examining individual or prevent the acceptance into evidence of the report of an examining individual in any proceeding before the committee or board.
   D. The power to dismiss complaints.

E. The power to dismiss complaints and issue letters of guidance or concern. A letter of guidance or concern may be used to educate, reinforce knowledge regarding legal or professional obligations and express concern over action or inaction by the licensee or registrant that does not rise to the level of misconduct sufficient to merit disciplinary action. The issuance of a letter of guidance or concern is not a formal proceeding and does not constitute an adverse disciplinary action of any form. Notwithstanding any provision of law to the contrary, a letter of guidance or concern is not confidential. The board may place a letter of guidance or concern, together with any underlying complaint, report and investigation materials, in a licensee's or registrant's file for a specified amount of time, not to exceed 10 years. Any letters, complaints and materials placed on file may be accessed and considered by the board in any subsequent action commenced against the licensee or registrant within the specified time frame. Complaints, reports and investigation materials placed on file are only confidential to the extent that confidentiality is required pursuant to Title 24, chapter 21.

F. The power to hold an informal conference with a licensee or applicant for licensure or re-licensure. The committee shall provide the licensee with adequate notice of the informal conference and the issues to be discussed. The complainant may attend and may be accompanied by up to 2 individuals, including legal counsel. The conference must be conducted in executive session of the committee, pursuant to Title 1, section 405, unless otherwise requested by the licensee. Before the committee decides what action to take at the conference or as a result of the conference, the committee shall give the complainant a reasonable opportunity to speak. Statements made at the conference may not be introduced at a subsequent formal hearing unless all parties consent. The complainant, the licensee or either of their representatives shall maintain the confidentiality of the informal conference.

G. The power, with the consent of the licensee, to enter into a consent agreement that resolves an investigation and that fixes the period and terms of probation best adapted to protect the public health and safety and rehabilitate or educate the licensee. Consent agreements may be entered into only with the consent of the applicant or licensee, the investigative committee, and the Department of the Attorney General. Any remedy, penalty or fine or cost recovery that is otherwise available by law, even if only in the jurisdiction of the District Court, may be achieved by consent agreement, including long-term suspension and permanent revocation of a professional license. A consent agreement is not subject to review or appeal and may be modified only by a writing executed by all parties to the original consent agreement. A consent agreement is enforceable by the board and by an action in Superior Court.

H. The power to accept a voluntary surrender of a license or privilege, in consideration of which, the committee may negotiate stipulations, including terms and conditions for reinstatement, that ensure protection of the public health and safety and serve to rehabilitate or educate the licensee. These stipulations may be set forth only in a consent agreement signed by the board, the licensee and the Attorney General's office.

I. If the committee concludes that modification or nonrenewal of the license is in order, the board shall hold an adjudicatory hearing in accordance with Title 5, chapter 375, subchapter 4.

J. The power to refer the investigation to an adjudicatory hearing before the board or to the Office of Attorney General to file a complaint in the District Court in accordance with Title 4, chapter 5.

K. The power to conduct adjudicatory hearings referred by the other investigative committee.

3. Adjudicatory hearings.

A. Adjudicatory hearings will be conducted by an adjudicatory hearing panel comprised solely of a subset of board members, with a minimum quorum of five members serving as an

adjudicatory hearing panel. A board member cannot serve on an adjudicatory hearing if they participated in the review and investigation of the licensee or applicant for licensure being adjudicated.

B. Adjudicatory hearings held by adjudicatory hearing panels shall be conducted consistent with MAPA.
C. Presiding officer. There shall be a presiding officer who shall conduct each board hearing, as determined by the adjudicatory hearing panel or by board rule.
D. Rulemaking regarding adjudicatory hearings. The board may promulgate rules governing its adjudicatory hearings, which shall be routine technical rulemaking.

§XXXX. Complaints; reports; investigations

Procedure. The board, acting through the investigation committee, shall investigate a complaint, on its own motion or upon receipt of a written complaint filed with the board, regarding alleged noncompliance with or violation of this chapter or any rules adopted by the board. The board shall notify the licensee of the content of a complaint filed against the licensee as soon as possible, but not later than 60 days after receipt of this information. The licensee shall respond within 30 days. The board shall share the licensee's response with the complainant, unless the board determines that it would be detrimental to the health of the complainant to obtain the response or that the complainant is not legally entitled to the confidential medical information contained in the response. Board staff shall ensure that the complaint is referred to the appropriate investigative committee for review. When a complaint has been filed against a licensee and the licensee moves or has moved to another state, the board may report to the appropriate licensing board in that state the complaint that has been filed, other complaints in the physician's record on which action was taken and disciplinary actions of the board with respect to that physician.

When an individual applies for a license under this chapter, the board, acting through the investigation committee, may investigate the professional record of that individual, including professional records that the individual may have as a licensee in other states. The board may deny a license or authorize a restricted license based on the record of the applicant in other states or for any reason enumerated in this chapter that constitutes grounds for discipline.

When the board receives a report pursuant to Title 24, Section 2505 or 2506, regarding a licensee, board staff shall ensure that the report is referred to the appropriate investigative committee for review. Following review, the investigation committee may close the matter without action, further investigate or open a complaint.

§XXXX. Emergency action Upon its own motion or upon complaint, the board, or an investigative committee of the board, in the interests of public health, safety and welfare, shall treat as an emergency a complaint or allegation that an individual licensed under this chapter is or may be unable to practice medicine with reasonable skill and safety to patients by reason of mental illness, alcohol intemperance, excessive use of drugs, narcotics or as a result of a mental or physical condition interfering with the competent practice of medicine. In enforcing this paragraph, the board, or an investigative committee of the board, may compel a physician to submit to a mental or physical examination by a physician or another person designated by the board. Failure of a physician to submit to this examination when directed constitutes an admission of the allegations against the physician, unless the failure was due to circumstances beyond the physician's control, upon which a final order of disciplinary action may be entered without the taking of testimony or presentation of evidence. A physician affected under this paragraph must, at reasonable intervals, be afforded an opportunity to demonstrate that the physician can resume the competent practice of medicine with reasonable skill and safety to patients.

For the purpose of this chapter, by practicing or by making and filing a biennial license to practice medicine in this State, every physician licensed under this chapter who accepts the privilege to practice medicine in this State is deemed to have given consent to a mental or physical examination when directed in writing by

the board and to have waived all objections to the admissibility of the examiner's testimony or examination reports on the grounds that the testimony or reports constitute a privileged communication.

Injunctions must issue immediately to enjoin the practice of medicine by an individual licensed to practice under this chapter when that individual's continued practice will or may cause irreparable damage to the public health or safety prior to the time proceedings under this chapter could be instituted and completed. In a petition for injunction pursuant to this section, there must be set forth with particularity the facts that make it appear that irreparable damage to the public health or safety will or may occur prior to the time proceedings under this chapter could be instituted and completed. The petition must be filed in the name of the board on behalf of the State.

§XXXX. Disciplinary action; judicial review

1. **Disciplinary action.** In addition to the powers under Title 10, section 8003, subsection 5-A, the board may suspend, revoke or refuse to issue or renew a license or privilege pursuant to Title 5, section 10004. The following are grounds for an action to refuse to issue, modify, suspend, revoke or refuse to renew the license of a person licensed under this chapter:
    - A. The practice of fraud, deceit or misrepresentation in obtaining a license or authority from the board or in connection with services within the scope of the license or authority;
    - B. Misuse of alcohol, drugs or other substances that has resulted or may result in the licensee performing services in a manner that endangers the health or safety of patients;
    - C. A professional diagnosis of a mental or physical condition that has resulted or may result in the licensee performing services in a manner that endangers the health or safety of patients;
    - D. Aiding or abetting the practice of medicine or rendering of medical services by an individual who is not licensed under this chapter and who has not been properly delegated the task and who claims to be legally licensed;
    - E. Incompetence in the practice for which the licensee is licensed or authorized by the board. A licensee is considered incompetent in the practice if the licensee has:
    - i. Engaged in conduct that evidences a lack of ability or fitness to perform the duties owed by the licensee to a client or patient or the general public; or
    - ii. Engaged in conduct that evidences a lack of knowledge or inability to apply principles or skills to carry out the practice for which the licensee is licensed;
    - F. Unprofessional conduct. A licensee is considered to have engaged in unprofessional conduct if the licensee violates a standard of professional behavior, including engaging in disruptive behavior, that has been established in the practice for which the licensee is licensed. For purposes of this paragraph, "disruptive behavior" means aberrant behavior that interferes with or is likely to interfere with the delivery of care;
    - G. Subject to the limitations of Title 5, chapter 341, conviction of a crime that involves dishonesty or false statement or that relates directly to the practice for which the licensee is licensed or authorized by the board, or conviction of a crime for which incarceration for one year or more may be imposed;
    - H. A violation of this chapter or a rule adopted by the board;
    - I. Engaging in false, misleading or deceptive advertising;
    - J. Prescribing drugs listed as controlled substances by the United States Drug Enforcement Administration for other than accepted therapeutic purposes;
    - K. Failure to report to the board a physician or physician associate licensed under this chapter or a physician associate privileged under the PA Compact, in accordance with Title 24, section 2505;
    - L. Failure to comply with the requirements of Title 24, section 2905-A;
    - M. Revocation, suspension or restriction of a license to practice medicine or other disciplinary action; denial of an application for a license; or surrender of a license to practice medicine

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following the institution of disciplinary action by another state or a territory of the United States or a foreign country if the conduct resulting in the disciplinary or other action involving the license would, if committed in this State, constitute grounds for discipline under the laws or rules of this State;

N. Engaging in any activity requiring a license under the governing law of the board that is beyond the scope of acts authorized by the license held

O. Continuing to act in a capacity requiring a license or authority under this chapter or a rule adopted by the board after expiration, suspension or revocation of that license or authority;

P. Noncompliance with an order of or consent agreement executed by the board;

Q. Failure to produce any requested documents in the licensee's possession or under the licensee's control relevant to a pending complaint, proceeding or matter under investigation by the board;

R. Failure to timely respond to a complaint notification sent by the board;

S. Failure to comply with the requirements of Title 22, section 7253;

T. Advertising, offering or administering conversion therapy to a minor.

2. **Judicial review.** Notwithstanding any provision of Title 10, section 8003, subsection 5 to the contrary, any nonconsensual revocation pursuant to Title 10, section 8003, subsection 5 of a license or authority issued by the board may be imposed only after a hearing conforming to the requirements of Title 5, chapter 375, subchapter 4 and is subject to judicial review exclusively in the Superior Court in accordance with Title 5, chapter 375, subchapter 7.

3. **Letters of guidance.** In addition to the authority conferred under Title 10, section 8003, subsection 5, the board may issue a letter of guidance or concern to a licensee or registrant. A letter of guidance or concern may be used to educate, reinforce knowledge regarding legal or professional obligations and express concern over action or inaction by the licensee or registrant that does not rise to the level of misconduct sufficient to merit disciplinary action. The issuance of a letter of guidance or concern is not a formal proceeding and does not constitute an adverse disciplinary action of any form. Notwithstanding any provision of law to the contrary, a letter of guidance or concern is not confidential. The board may place a letter of guidance or concern, together with any underlying complaint, report and investigation materials, in a licensee's or registrant's file for a specified amount of time, not to exceed 10 years. Any letters, complaints and materials placed on file may be accessed and considered by the board in any subsequent action commenced against the licensee or registrant within the specified time frame. Complaints, reports and investigation materials placed on file are only confidential to the extent that confidentiality is required pursuant to Title 24, chapter 21.

SUBCHAPTER 5

DELEGATION; SCOPE OF PRACTICE; REQUIREMENTS; STANDARDS

§XXXX. Delegation by physicians and physician associates

A physician or physician associate may delegate to the physician's or physician associate's employees or support staff or members of a health care team, including medical assistants, certain activities relating to medical care and treatment carried out by custom and usage when the activities are under the control of the physician or physician associate; the activities being delegated do not, unless otherwise provided by law, require a license, privilege, registration or certification to perform; the physician or physician associate ensures that the employees or support staff or members of a health care team have the appropriate training, education and experience to perform these delegated activities; and the physician or physician associate ensures that the employees or support staff perform these delegated activities competently and safely. The physician or physician associate who delegates an activity permitted under this subsection to employees or support staff, to program graduates or to participants in an approved training program is legally liable for the activity performed by these

individuals, and any individual in this relationship is considered the physician's or physician associate's agent. This section may not be construed to apply to registered nurses acting pursuant to Chapter 31 or physician associate acting pursuant to this chapter.

When the delegated activities are part of the practice of optometry as defined in chapter 151, then the individual to whom these activities are delegated must possess a valid license to practice optometry in Maine, or otherwise may perform only as a technician within the established office of a physician, and otherwise acting solely on the order of and under the responsibility of a physician skilled in the treatment of eyes as designated by the proper professional board, and without assuming evaluation or interpretation of examination findings by prescribing corrective procedures to preserve, restore or improve vision.

§XXXX Physician associates; scope of practice and agreement requirements

1. **Scope of practice.** A physician associate may render any medical service for which the physician associate has been prepared by education, training and experience and is competent to perform. The scope of practice of a physician associate is determined by practice setting, including, but not limited to, a physician employer setting, physician group practice setting or independent private practice setting, or, in a health care facility setting, by a system of credentialing and granting of privileges.
2. **Dispensing drugs.** Except for distributing a professional sample of a prescription or legend drug, a physician associate who dispenses a prescription or legend drug:
    A. Shall comply with all relevant federal and state laws and federal regulations and state rules; and
    B. May dispense the prescription or legend drug only when:
        1. A pharmacy service is not reasonably available;
        2. Dispensing the drug is in the best interests of the patient; or
        3. An emergency exists.
3. **Consultation.** A physician associate shall, as indicated by a patient's condition, the education, competencies and experience of the physician associate and the standards of care, consult with, collaborate with or refer the patient to an appropriate physician or other health care professional. The level of consultation required under this subsection is determined by the practice setting, including a physician employer, physician group practice, or private practice, or by the system of credentialing and granting of privileges of a health care facility. A physician must be accessible to the physician associate at all times for consultation. Consultation may occur electronically or through telecommunication and includes communication, task sharing and education among all members of a health care team.
4. **Collaborative agreement requirements.** A physician associate with less than 4,000 hours of clinical practice documented to the board shall work in accordance with a collaborative agreement with an active physician that describes the physician associate's scope of practice, except that a physician associate working in a physician group practice setting or a health care facility setting under a system of credentialing and granting of privileges and scope of practice agreement may use that system of credentialing and granting of privileges and scope of practice agreement in lieu of a collaborative agreement. A physician associate is legally responsible and assumes legal liability for any medical service provided by the physician associate in accordance with the physician associate's scope of practice under subsection 2 and a collaborative agreement under this subsection. Under a collaborative agreement, collaboration may occur through electronic means and does not require the physical presence of the physician at the time or place that the medical services are provided. A physician associate shall submit the collaborative agreement, or, if appropriate, the scope of practice agreement, to the board for approval and the agreement must be kept on file at the main location of the place of practice and be made available to the board or the

board's representative upon request. Upon submission to the board of documentation of 4,000 hours of clinical practice, a physician associate is no longer subject to the requirements of this subsection.

5. **Practice agreement requirements.** A physician associate who has more than 4,000 hours of clinical practice may be the principal clinical provider in a practice that does not include a physician partner as long as the physician associate has a practice agreement with an active physician, and other health care professionals as necessary, that describes the physician associate's scope of practice. A physician associate is legally responsible and assumes legal liability for any medical service provided by the physician associate in accordance with the physician associate's scope of practice under subsection 2 and a practice agreement under this subsection. A physician associate shall submit the practice agreement to the board for approval and the agreement must be kept on file at the main location of the physician associate's practice and be made available to the board or the board's representative upon request. Upon any change in the parties to the practice agreement or other substantive change in the practice agreement, the physician associate shall submit the revised practice agreement to the board for approval. Under a practice agreement, consultation may occur through electronic means and does not require the physical presence of the physician or other health care providers who are parties to the agreement at the time or place that the medical services are provided.
6. **Construction.** To address the need for affordable, high-quality health care services throughout the State and to expand, in a safe and responsible manner, access to health care providers such as physician associates, this section must be liberally construed to authorize physician associates to provide health care services to the full extent of their education, training and experience in accordance with their scopes of practice as determined by their practice settings.

§XXXX. Review committee immunity

A physician or physician associate licensed under this chapter who is a member of a utilization review committee, medical review committee, surgical review committee, peer review committee or disciplinary committee that is a requirement of accreditation by the Joint Commission on Accreditation of Hospitals or is established and operated under the auspices of the physician's or physician associate's respective state or county professional society or the Maine Board of Medicine is immune from civil liability for undertaking or failing to undertake an act within the scope of the function of the committee.

§XXXX. Records of proceedings of medical staff review committees confidential

All proceedings and records of proceedings concerning medical staff reviews, hospital reviews and other reviews of medical care conducted by committees of physicians and other health care personnel on behalf of hospitals located within the State or on behalf of individual physicians, when the reviews are required by state or federal law, rule or as a condition of accreditation by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association Committee on Hospital Accreditation or are conducted under the auspices of the state or county professional society to which the physician belongs, are confidential and are exempt from discovery.

Provision of information protected by this section to the board pursuant to Title 24, section 2506 does not waive or otherwise affect the confidentiality of the records or the exemption from discovery provided by this section for any other purpose.

§XXXX. Lyme disease treatment

1. **Definitions.** As used in this section, unless the context otherwise indicates, the following terms have the following meanings.
    A. "Long-term antibiotic therapy" means the administration of oral, intramuscular or intravenous antibiotics, singly or in combination, for a period of time in excess of 4 weeks.
    B. "Lyme disease" means:
        1. The presence of signs or symptoms compatible with acute infection with Borrelia burgdorferi;

2. Late stage, persistent or chronic infection with Borrelia burgdorferi;
3. Complications related to an infection under subparagraph (1) or (2); or
4. The presence of signs or symptoms compatible with acute infection or late stage, persistent or chronic infection with other strains of Borrelia that are identified or recognized by the United States Department of Health and Human Services, Centers for Disease Control and Prevention as a cause of disease.

"Lyme disease" includes an infection that meets the surveillance criteria for Lyme disease established by the federal Centers for Disease Control and Prevention or a clinical diagnosis of Lyme disease that does not meet the surveillance criteria for Lyme disease set by the federal Centers for Disease Control and Prevention but presents other acute and chronic signs or symptoms of Lyme disease as determined by a patient's treating physician

2. Lyme disease treatment. A physician licensed under this chapter may prescribe, administer or dispense long-term antibiotic therapy for a therapeutic purpose to eliminate infection or to control a patient's symptoms upon making a clinical diagnosis that the patient has Lyme disease or displays symptoms consistent with a clinical diagnosis of Lyme disease. The physician shall document the clinical diagnosis and treatment in the patient's medical record. The clinical diagnosis must be based on knowledge obtained through medical history and physical examination only or in conjunction with testing that provides supportive data for the clinical diagnosis.

§XXXX. Treatment of minors

An individual licensed under this chapter who renders medical care to a minor for the prevention or treatment of a sexually transmitted infection or treatment of substance use or for the collection of sexual assault evidence through a sexual assault forensic examination is under no obligation to obtain the consent of the minor's parent or guardian or to inform the parent or guardian of the prevention or treatment or collection. This section may not be construed to prohibit the licensed individual rendering the prevention services or treatment or collection from informing the parent or guardian. For purposes of this section, "substance use" means the use of drugs or alcohol solely for their stimulant, depressant or hallucinogenic effect upon the higher functions of the central nervous system and not as a therapeutic agent recommended by a practitioner in the course of medical treatment.

§XXXX. . Posting of policy regarding acceptance of Medicare assignment

A person licensed to practice medicine or render medical services under this chapter, or privileged under the PA Compact, a chiropractor licensed pursuant to chapter 9 and a podiatrist licensed pursuant to chapter 51 who treats Medicare-eligible individuals shall post in a conspicuous place that professional's policy regarding the acceptance of Medicare assignment. This posting must state the policy on accepting assignment and name the individual with whom the patient should communicate regarding the policy.

The Board of Licensure in Medicine, the Board of Osteopathic Licensure, the Board of Licensure of Podiatric Medicine and the Board of Chiropractic Licensure shall enforce the provisions of this section and inform each licensee of the licensee's obligation under this law. Each board may discipline a licensee under its jurisdiction for failing to comply with this section and impose a monetary penalty of not less than $100 and not more than $1,000 for each violation.

§XXXX. Release of contact lens prescription

After contact lenses have been adequately fitted and the patient released from immediate follow-up care by the physician, the patient may request a copy of the contact lens specifications from the physician. The physician shall provide a copy of the prescription, at no cost, which must contain the information necessary to properly duplicate the current prescription. The contact lens prescription must

contain an expiration date not to exceed 24 months from the date of issue. The prescription may contain fitting guidelines and may also contain specific instructions for use by the patient.

The prescribing physician is not liable for an injury to or a condition of a patient that results from negligence in packaging, manufacturing or dispensing lenses by anyone other than the prescribing physician.

The dispensing party may dispense contact lenses only upon receipt of a written prescription, except that a physician may fill a prescription of an optometrist or another physician without a copy of the prescription. Mail order contact lens suppliers must be licensed by and register with the Board of Pharmacy pursuant to section 13751, subsection 3-A and are subject to discipline by that board for violations of that board's rules and the laws governing the board. An individual who fills a contact lens prescription shall maintain a file of that prescription for a period of 5 years. An individual, a corporation or any other entity, other than a mail order contact lens supplier, that improperly fills a contact lens prescription or fills an expired prescription commits a civil violation for which a forfeiture of not less than $250 nor more than $1,000 may be adjudged. An individual may file a complaint with the board seeking disciplinary action concerning violations of this section.

§XXXX. Expedited partner therapy

An individual licensed under this chapter may not be disciplined for providing expedited partner therapy in accordance with the provisions of Title 22, chapter 251, subchapter 3, article 5.

§XXXX. Issuance of prescription for ophthalmic lenses

A physician licensed by the board may not issue a prescription for ophthalmic lenses, as defined in section 19101, subsection 18, solely in reliance on a measurement of the eye by a kiosk, as defined in section 19101, subsection 13, without conducting an eye examination, as defined in section 19101, subsection 11.

§XXXX. Requirements regarding prescription of opioid medication

1. **Limits on opioid medication prescribing.** Except as provided in subsection 2, an individual licensed under this chapter and whose scope of practice includes prescribing opioid medication may not prescribe:
    A. To a patient any combination of opioid medication in an aggregate amount in excess of 100 morphine milligram equivalents of opioid medication per day;
    B. To a patient who, on the effective date of this section, has an active prescription for opioid medication in excess of 100 morphine milligram equivalents of an opioid medication per day, an opioid medication in an amount that would cause that patient's total amount of opioid medication to exceed 300 morphine milligram equivalents of opioid medication per day; except that, on or after July 1, 2017, the aggregate amount of opioid medication prescribed may not be in excess of 100 morphine milligram equivalents of opioid medication per day;
    C. Within a 30-day period, more than a 30-day supply of an opioid medication to a patient under treatment for chronic pain. "Chronic pain" has the same meaning as in Title 22, section 7246, subsection 1-C; or
    D. Within a 7-day period, more than a 7-day supply of an opioid medication to a patient under treatment for acute pain unless the opioid product is labeled by the federal Food and Drug Administration to be dispensed only in a stock bottle that exceeds a 7-day supply as prescribed, in which case the amount dispensed may not exceed a 14-day supply. "Acute pain" has the same meaning as in Title 22, section 7246, subsection 1-A.
2. **Exceptions.** An individual licensed under this chapter whose scope of practice includes prescribing opioid medication is exempt from the limits on opioid medication prescribing established in subsection 1 only:

A. When prescribing opioid medication to a patient for:
   1. Pain associated with active and aftercare cancer treatment;
   2. Palliative care, as defined in Title 22, section 1726, subsection 1, paragraph A, in conjunction with a serious illness, as defined in Title 22, section 1726, subsection 1, paragraph B;
   3. End-of-life and hospice care;
   4. Medication-assisted treatment for substance use disorder; or
   5. Other circumstances determined in rule by the Department of Health and Human Services pursuant to Title 22, section 7254, subsection 2; and

B. When directly ordering or administering a benzodiazepine or opioid medication to a person in an emergency room setting, an inpatient hospital setting, a long-term care facility or a residential care facility or in connection with a surgical procedure.

As used in this paragraph, "administer" has the same meaning as in Title 22, section 7246, subsection 1-B.

3. **Electronic prescribing.** An individual licensed under this chapter and whose scope of practice includes prescribing opioid medication with the capability to electronically prescribe shall prescribe all opioid medication electronically by July 1, 2017. An individual who does not have the capability to electronically prescribe must request a waiver from this requirement from the Commissioner of Health and Human Services stating the reasons for the lack of capability, the availability of broadband infrastructure, and a plan for developing the ability to electronically prescribe opioid medication. The commissioner may grant a waiver including circumstances in which exceptions are appropriate, including prescribing outside of the individual's usual place of business and technological failures.
4. **Continuing education.** By December 31, 2017, an individual licensed under this chapter must successfully complete 3 hours of continuing education every 2 years on the prescription of opioid medication. The board shall adopt rules to implement this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
5. **Penalties.** An individual who violates this section commits a civil violation for which a fine of $250 per violation, not to exceed $5,000 per calendar year, may be adjudged. The Department of Health and Human Services is responsible for the enforcement of this section.
6. **Opioid medication policy.** No later than January 1, 2018, a health care entity that includes an individual licensed under this chapter whose scope of practice includes prescribing opioid medication must have in place an opioid medication prescribing policy that applies to all prescribers of opioid medications employed by the entity. The policy must include, but is not limited to, procedures and practices related to risk assessment, informed consent and counseling on the risk of opioid use. For the purposes of this subsection, "health care entity" has the same meaning as in Title 22, section 1718-B, subsection 1, paragraph B.

§XXXX. Prohibition on providing conversion therapy to minors

An individual licensed, registered or certified under this chapter may not advertise, offer or administer conversion therapy to a minor.

§XXXX. Duty to warn and protect

1. **Duty.** A licensee of the board has a duty to warn of or to take reasonable precautions to provide protection from a patient's violent behavior if the physician has a reasonable belief based on communications with the patient that the patient is likely to engage in physical violence that poses a serious risk of harm to self or others. The duty imposed under this subsection may not be interpreted to require the licensee to take any action that in the reasonable professional judgment of the licensee would endanger the licensee or increase the threat of danger to a potential victim.

2. **Discharge of duty.** A licensee subject to a duty to warn or provide protection under subsection 1 may discharge that duty if the licensee makes reasonable efforts to communicate the threat to a potential victim, notifies a law enforcement agency or seeks involuntary hospitalization of the patient under Title 34-B, chapter 3, subchapter 4, article 3.
3. **Immunity.** No monetary liability and no cause of action may arise concerning patient privacy or confidentiality against a licensee for information disclosed to 3rd parties in an effort to discharge a duty under subsection 2.

SUBCHAPTER 6

TELEHEALTH SERVICES

§XXXX. Definitions

As used in this subchapter, unless the context otherwise indicates, the following terms have the following meanings.

1. **Asynchronous encounter.** "Asynchronous encounter" means an interaction between a patient and a person licensed under this chapter through a system that has the ability to store digital information, including, but not limited to, still images, video files, audio files, text files and other relevant data, and to transmit such information without requiring the simultaneous presence of the patient and the person licensed under this chapter.
2. **Store and forward transfer.** "Store and forward transfer" means the transmission of a patient's records through a secure electronic system to a person licensed under this chapter.
3. **Synchronous encounter.** "Synchronous encounter" means a real-time interaction conducted with an interactive audio or video connection between a patient and a person licensed under this chapter or between a person licensed under this chapter and another health care provider.
4. **Telehealth services.** "Telehealth services" means health care services delivered through the use of information technology and includes synchronous encounters, asynchronous encounters, store and forward transfers and telemonitoring.
5. **Telemonitoring.** "Telemonitoring" means the use of information technology to remotely monitor a patient's health status via electronic means, allowing the person licensed under this chapter to track the patient's health data over time. Telemonitoring may be synchronous or asynchronous.

§XXXX. Telehealth services permitted

A person licensed under this chapter may provide telehealth services as long as the licensee acts within the scope of practice of the licensee's license, in accordance with any requirements and restrictions imposed by this subchapter and in accordance with standards of practice.

§XXXX. Confidentiality

When providing telehealth services, a person licensed under this chapter shall comply with all state and federal confidentiality and privacy laws.

§XXXX. Professional responsibility

All laws and rules governing professional responsibility, unprofessional conduct and generally accepted standards of practice that apply to a person licensed under this chapter also apply to that licensee while providing telehealth services.

§XXXX. Rulemaking

The board shall adopt rules governing telehealth services by persons licensed under this chapter. These rules must establish standards of practice and appropriate restrictions for the various types and

Commented [TT15]: §3300-D. Interstate practice of telehealth 1. Definition. For the purposes of this section, "telehealth" has the same meaning as in Title 24-A, section 4316, subsection 1. 2. Requirements. A physician not licensed to practice medicine in this State may provide consultative services through interstate telehealth to a patient located in this State if the physician is registered in accordance with subsection 3. A physician intending to provide consultative services in this State through interstate telehealth shall provide any information requested by the board and complete information on: A. All states and jurisdictions in which the physician is currently licensed; B. All states and jurisdictions in which the physician was previously licensed; and 28 | Chapter 48. BOARD OF LICENSURE IN MEDICINE Generated 01.07.2025MRS Title 32, Chapter 48. BOARD OF LICENSURE IN MEDICINE C. All negative licensing actions taken previously against the physician in any state or jurisdiction. 3. Registration. The board may register a physician to practice medicine in this State through interstate telehealth if the following conditions are met: A. The physician is fully licensed without restriction to practice medicine in the state from which the physician provides telehealth services; B. The physician has not had a license to practice medicine revoked or restricted in any state or jurisdiction; C. The physician does not open an office in this State, does not meet with patients in this State, does not receive calls in this State from patients and agrees to provide only consultative services as requested by a physician, advanced practice registered nurse or physician assistant licensed in this State and the physician, advanced practice registered nurse or physician assistant licensed in this State retains ultimate authority over the diagnosis, care and treatment of the patient; D. The physician registers with the board every 2 years, on a form provided by the board; and E. The physician pays a registration fee not to exceed $500. 4. Notification of restrictions. A physician registered to provide interstate telehealth services under this section shall immediately notify the board of restrictions placed on the physician's license to practice medicine in any state or jurisdiction. 5. Jurisdiction. In registering to provide interstate telehealth services to residents of this State under this section, a physician agrees to be subject to the laws and judicial system of this State and board rules with respect to providing medical services to residents of this State. 6. Notification to other states. The board shall obtain confirmation of licensure from all states and jurisdictions in which a physician applying for registration has ever been licensed prior to registering the physician pursuant to subsection 3. The board shall request notification from a state or jurisdiction if future adverse action is taken against the physician's license in that state or jurisdiction.

forms of telehealth services. Rules adopted pursuant to this section are routine technical rules as defined by Title 5, chapter 375, subchapter 2-A.

PART B

§XXXX. Transition. Notwithstanding the Maine Revised Statutes, Title 32, Chapters 36 and 48, the following provisions apply to the reassignment of the duties and responsibilities related to the licensing and regulation of allopathic physicians, osteopathic physicians and physician associates in Maine:

1. The Maine Board of Medicine is created and established by law. All other statutory references to, responsibilities of and authority conferred upon the Maine Board of Licensure in Medicine and the Maine Board of Osteopathic Licensure are deemed to refer to and vest in the Maine Board of Medicine created by this Act. The Maine Board of Medicine is the successor in every way to the powers, duties and functions related to the licensure and regulation of physicians and physician associates in Maine.
2. Notwithstanding the provisions of Title 5, all accrued expenditures, assets, liabilities, balances of appropriations, allocations, transfers, revenues or other available funds in an account or subdivision of an account of the Board of Licensure in Medicine and the Board of Osteopathic Licensure must be transferred to the proper accounts of the Maine Board of Medicine by the State Controller or by financial order upon the request of the State Budget Officer and with the approval of the Governor.
3. All rules of the Board of Licensure in Medicine and the Board of Osteopathic Licensure that are in effect on the effective date of this Act remain in effect until rescinded, revised or amended.
4. All contracts, agreements and compacts of the Board of Licensure in Medicine and the Board of Osteopathic Licensure as they pertain to the duties set forth in this Act that are in effect on the effective date of this Act remain in effect until they expire or are altered by the parties involved in the contracts or agreements. The Maine Board of Medicine is the successor agency for all contracts, agreements and compacts of the Board of Licensure in Medicine and the Board of Osteopathic Licensure.
5. All records of the Board of Licensure in Medicine and the Board of Osteopathic Licensure as they pertain to the duties set forth in this Act must be transferred to the Maine Board of Medicine as necessary to implement this Act.
6. All property and equipment of the Board of Licensure in Medicine and the Board of Osteopathic Licensure pertaining to the duties set forth in this Act are transferred to the Maine Board of Medicine as necessary to implement this Act.
7. Employees of the Board of Licensure in Medicine and the Board of Osteopathic Licensure who were employees of those respective boards immediately prior to the effective date of this Act retain all their employee rights, privileges and benefits, including sick leave, vacation and seniority, provided under the Civil Service Law or collective bargaining agreements. The Department of Administrative and Financial Services, Bureau of Human Resources shall provide assistance to the affected employees and the Maine Board of Medicine and shall assist with the orderly implementation of this subsection.
8. By January 31, 2027, the Maine Board of Medicine shall submit a report, including recommendations for any proposed legislation, to the Governor and the joint standing committee of the Legislature having jurisdiction over professional licensing boards.
9. The Department of Administrative and Financial Services, Bureau of the Budget shall work with employees of the Maine Board of Medicine with regard to the duties transferred to it as set forth in this Act to develop the budget for the Maine Board of Medicine.
10. All complaints and investigations in progress at the time this legislation takes effect will be assigned to one of the combined Board's investigative committees and no licensee with a pending matter at the time of the merger shall be entitled to challenge any member of that committee who previously

heard the matter when sitting as a member of the Board of Licensure in Medicine or the Board of Osteopathic Licensure.

§XXXX. Enactment. This legislation will take effect on _____

Maine Osteopathic Association

November 12, 2025

Maine Board of Osteopathic Licensure
Attn: Rachel MacArthur, Executive Secretary
Via Email: rachel.macarthur@maine.gov; OSTEO.PFR@maine.gov

Re: BOL Meeting – November 13, 2025, Item 5C BOL/BOLIM Merger Feasibility Report/Vote

Dear Members of the Board of Osteopathic Licensure,

On behalf of the Maine Osteopathic Association (MOA) and the osteopathic physicians we represent across the state, I write regarding the upcoming November 13th Board meeting, during which I understand that the Board of Osteopathic Licensure will review the work of the BOL/BOLIM merger feasibility workgroup and subsequently take a vote of the board on how to move this process forward.

We appreciate the thoughtfulness and transparency of the BOL and the workgroup's process to date and the genuine respect shown for osteopathic medicine throughout these discussions. However, we continue to have deep concerns about how a merged DO/MD/PA licensing board structure could affect the long-term representation of DOs, as well as public protections that depend upon effective self-regulation within the osteopathic profession.

While the current draft vision for a unified "Maine Medical Board" includes a preamble declaring intent to preserve osteopathic identity, there are no guarantees that this respect and understanding will continue in perpetuity. The osteopathic approach to care—rooted in whole-person philosophy, hands-on treatment, and preventive focus—represents an essential and distinct standard of care. These principles not only differentiate DOs but also directly serve the public interest.

As NBOME noted in its recent letter to the Board, Maine's osteopathic physicians play an outsized role in addressing rural physician shortages, providing primary care, and ensuring access to treatment in underserved regions. Combining boards could unintentionally weaken these contributions while introducing new financial and administrative burdens without clear cost savings or efficiencies.

Furthermore, adequate and qualified representation of osteopathic physicians on any governing body that oversees licensure, discipline, and policy decisions is non-negotiable to maintaining public trust and professional integrity. The osteopathic voice must remain strong and independent in the regulatory landscape of Maine medicine.

We respectfully urge the Board to carefully consider its vote. Perhaps alternatives to a combined board might strengthen collaboration while preserving independent governance. Perhaps continued investment in appropriate BOL staffing and shared service contracts between boards could enhance efficiency without compromising identity or oversight. Perhaps the boards, and the joint workgroup would benefit from more time to consider all options and come to agreement on the best path forward.

Thank you for your service and for considering the perspectives of the osteopathic community on this important issue. The MOA stands ready to continue engaging constructively to ensure that Maine's licensing system protects patients while supporting all physicians in their work to deliver high-quality care.

Respectfully,
Kathryn Brandt
Kathryn Brandt, DO, MS.MEdL, President, Maine Osteopathic Association, President@mainedo.org

AMERICAN
OSTEOPATHIC ASSOCIATION

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Chicago, IL 60611
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TO: Members of the Maine Board of Osteopathic Licensure (BOL)

FROM: American Osteopathic Association

DATE: November 12, 2025

SUBJECT: BOL/BOLIM Merger Workgroup Proposal – Opposition to

The American Osteopathic Association (AOA) writes to share our strong concerns with the proposal to merge the BOL and the Maine Board of Licensure in Medicine (BOLIM), which is scheduled for a vote during your November 13, 2025 meeting. We are grateful to have had the opportunity to voice our concerns – which are shared by the Maine Osteopathic Association (MOA) and the National Board of Osteopathic Medical Examiners (NBOME) – during meetings of the Board Merger Workgroup (Workgroup); however, we are concerned that the Workgroup was designed with a preconceived goal in mind (namely, a merger) and that alternative proposals were not given sufficient weight. Therefore, we write to reiterate our strong support for maintaining a separate and distinct BOL, for reasons which are discussed in more detail below.

As a medical professional association representing more than 207,000 DOs and osteopathic medical students (OMSs) nationwide – including over 700 currently attending the University of New England College of Osteopathic Medicine in Biddeford, Maine – the AOA works to promote evidence-based policies and sound public health practices that advance the overall health and wellbeing of patients across the country. Together with the MOA and the NBOME, our mission is to uphold high standards of patient care, preserve the integrity of osteopathic professional self-regulation, and protect the distinct identity of osteopathic medicine. We believe that the patients and profession in Maine are best served by separate and distinct medical boards comprised of a majority of the professionals they regulate, as is the current structure in Maine.

As you know, while DOs and allopathic physicians (MDs) complete similar foundational education, DOs *additionally* receive several hundred hours of specialized training in osteopathic principles and practice, including osteopathic manipulative treatment (OMT) — a hands-on approach to diagnosing and treating patients that promotes the body's innate ability to heal itself. This whole-person philosophy, focusing on body, mind, and spirit, underpins osteopathic medical education and practice.

OMT has been shown to provide effective relief for a variety of complex conditions, including chronic low back pain, while reducing reliance on opioids and other

pharmacologic interventions.[1] Because of this unique approach to care, DOs pursue primary care specialties and serve in rural and underserved areas at higher rates than MDs.[2] This is of particular importance to Maine, where 11 of 16 counties are designated as Health Professional Shortage Areas or Medically Underserved Areas, affecting 40% of the state's population.[3]

The BOL, which has served the people of Maine for more than a century, has demonstrated consistent efficiency and fiscal self-sufficiency, operating entirely through licensure fees and fines without requiring state appropriations. Its thorough, DO-led approach to reviewing applications and complaints ensures the highest standards of professional conduct and patient safety. Our organizations are deeply concerned that eliminating the BOL and transferring DO regulation to the BOLIM (or a newly created equivalent) would compromise the effective regulation of osteopathic medicine and harm patient care, particularly since the BOLM must spend significant time and resources on international medical graduate (IMG) issues, which are not relevant to the BOL. **We urge the BOL to consider the following key points:**

1. **Representation and Equity:**
   History in other states demonstrates that when osteopathic and allopathic boards are merged, DOs rarely achieve equal representation with MDs. Under a merged structure, DOs would almost certainly have fewer members than they do now, diminishing their voice in decisions affecting their profession and patients.

   Currently, the BOL consists of eleven members appointed by the Governor, of which six are DOs. Even if proposed legislation were to specify that six out of twelve members of the merged board must be DOs (which is already less than the 54% majority that DOs have on the BOL), there is no guarantee that the provisions of the introduced version of the legislation will remain the same in the final, enacted version.

   Given that DOs would almost certainly end up with fewer seats and a lower representative percentage on a combined board than they currently possess, maintaining separate boards is critical to ensuring professional self-regulation and the safety of DO patients.

2. **Increased Board Workload Related to IMGs:**
   Unlike MD graduates, only graduates of United States (US)-based colleges of osteopathic medicine accredited by the Commission on Osteopathic College Accreditation are eligible for licensure as DOs in the US. Thus, the BOL is currently unencumbered with unrelated IMG issues; however, under a merged

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[1] Licciardone JC, et al. *Osteopathic Manipulation in the Management of Chronic Pain. J Am Osteopath Assoc.* 2020. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7381089/
[2] American Osteopathic Association. *2024 Osteopathic Medical Profession Report.* https://osteopathic.org/index.php?aam-media=/wp-content/uploads/2024-OMP-Report.pdf
[3] Maine Department of Health and Human Services. *Rural Health and Primary Care.* https://www.maine.gov/dhhs/mecdc/public-health-systems/rhpc/rural-health.shtml

board, DO board members would likely dedicate a significant portion of their time to IMG issues, detracting from the time and resources available to efficiently support DOs, and thus, patients.

With the Liaison Committee on Medical Education no longer accrediting Canadian MD-granting schools as of this year, and the potential adoption of Maine House Bill 105—which would create an additional licensing model (ALM) to license IMGs who have not completed any accredited graduate medical education in the US—the time spent by the BOLIM on IMG issues is projected to escalate significantly.

A Guidance Document issued by the Federation of State Medical Boards' joint *Advisory Commission on Additional Licensing Models*[4] this year outlines extensive new responsibilities for medical boards in assessing, supervising, and verifying credentials for IMGs in states that have adopted ALMs. These challenges are unique to MD licensing and irrelevant to DOs, yet a merged board would divert time and resources away from osteopathic licensure and complaint adjudication — ultimately slowing services, to the detriment of DOs and patients.

3. **Staffing and Fiscal Prudence:**
   Rather than pursuing a costly and disruptive merger, the AOA urges the BOL to adopt a more conservative approach; namely, hiring the second full-time employee whose salary has already been approved, and reevaluating the functioning of the board after a training period. This approach follows a suggestion by BOL staff that one additional FTE would likely suffice to effectively manage the board's workload, without triggering new, large-scale start-up and training costs, potential service disruptions, and unnecessary administrative complexity.

The independent structure of the BOL allows for a regulatory process tailored to osteopathic medicine's distinct philosophy and competencies. The BOL personally reviews each application to ensure compliance with the highest professional standards, while the BOLIM relies more heavily on staff-level approval processes. These differences reflect each board's professional culture and mission. Moreover, from the financial models presented to the Workgroup, it is unclear that creating a single, merged board would yield cost efficiencies. In recent years, states like Nevada and West Virginia have studied potential mergers and reached the same conclusion—that maintaining two strong, separate, and distinct boards provides greater clarity, efficiency, and protection for patients.

The AOA deeply values the BOL's thoughtful consideration of these issues and its commitment to safeguarding patient care. We urge you to maintain and strengthen the

[4] Advisory Commission on Additional Licensing Models (August 2025). *See* https://www.fsmb.org/siteassets/communications/acalm-guidance.pdf.

BOL as an independent, well-resourced entity, continuing its century-long legacy of effective professional self-regulation.

Thank you for allowing us the opportunity to contribute to this important discussion. Should you have any questions or require additional information, please feel free to contact Raine Richards, JD, AOA Vice President of State and International Affairs, at rrichards@osteopathic.org.

Sincerely,

Robert Piccinini, DO, D.FACN
President, AOA

CC: Richard Thacker, DO, President-elect, AOA
Jennifer Hauler, DO, Chair, Department of Governmental Affairs, AOA
J. Michael Wieting, DO, Chair, Council on State Health Affairs, AOA
Kathleen Creason, MBA, Chief Executive Officer, AOA
Raine Richards, JD, Vice President, State and International Affairs, AOA
Uma Loganathan, Associate, State Government Affairs, AOA