



STATE OF MAINE
DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION
BOARD OF LICENSURE IN MEDICINE
BOARD OF OSTEOPATHIC LICENSURE



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January 13, 2026

Senator Donna Bailey, Chair
Representative Kristi Mathieson, Chair
Committee on Health Coverage, Insurance and Financial Services
100 State House Station
Augusta, ME 04333

RE: LD805 Resolve, to Direct the Board of Licensure in Medicine and the Board of Osteopathic Licensure to Conduct a Study Regarding the Feasibility of Combining Those Boards

Dear Senator Bailey, Representative Mathieson and members of the committee,

Following discussion of LD805, the Committee on Health Coverage, Insurance and Financial Services sent a letter requesting that the Board of Licensure in Medicine (BOLIM) and the Board of Osteopathic Licensure (BOL) continue the work they had started to study the feasibility of merging the two boards and report back to the committee no later than January 15, 2026.

RECOMMENDATION

The BOLIM/BOL workgroup as well as the full BOLIM/BOL recommend merger of the two boards into a single board – The Maine Board of Medicine – that would license and regulate physicians and physician associates in Maine. To assist the Committee and the Legislature, the workgroup – in consultation with the boards – drafted the attached proposed legislation addressing how to feasibly merge the two boards.

At their December 2025 regularly scheduled board meetings, BOLIM and BOL voted in support of this recommendation and the attached proposed legislation, which specifically includes that the merged board would contain the same number of allopathic (MD) and osteopathic (DO) physician board members. BOL voted to recommend merger so long as there is an equal number of MD and DO physician members, a condition that BOLIM also voted to agree with. This recommendation and draft statutory language was arrived at following months of work by the workgroup and multiple discussions by the full BOLIM/BOL boards.

Just prior to this unified recommendation, at its November 2025 board meeting, BOLIM initially voted in favor of the merger, but not in favor of the single aspect of the draft statute that specified the physician board members must be comprised of six osteopathic and six allopathic physicians. However, following additional discussion at the November 2025 workgroup meeting and the December 2025 BOLIM meeting, BOLIM voted

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in favor of both the merger and the proposed statutory language that would require an equal number of osteopathic (six) and allopathic (six) physician board members as part of any unified board.

MEETINGS

The BOLIM/BOL Workgroup met twelve (12) times during 2025:

- January 28, 2025 7 BOLIM members and 5 BOL members in attendance.
- February 26, 2025 3 BOLIM members and 5 BOL members in attendance.
- March 26, 2025 4 BOLIM members and 8 BOL members in attendance.
- April 30, 2025 2 BOLIM members and 5 BOL members in attendance.
- May 28, 2025 2 BOLIM members and 4 BOL members in attendance.
- June 25, 2025 2 BOLIM members and 7 BOL members in attendance.
- July 23, 2025 2 BOLIM members and 7 BOL members in attendance.
- August 27, 2025 2 BOLIM members and 7 BOL members in attendance.
- September 24, 2025 2 BOLIM members and 5 BOL members in attendance.
- October 22, 2025 3 BOLIM members and 7 BOL members in attendance.
- November 19, 2025 5 BOLIM members and 7 BOL members in attendance.
- December 17, 2025 2 BOLIM members and 7 BOL members in attendance.

Meeting notes and information reviewed at the meetings can be found at <https://www.maine.gov/md/about/merger>.

PUBLIC NOTICE

The workgroup instructed that a webpage be created to list upcoming meetings and provide notes and materials from previous meetings. The webpage, <https://www.maine.gov/md/about/merger>, went live on April 11, 2025. Prior to that, notices of all workgroup meetings were posted on the BOLIM and BOL websites and notices were sent to the Maine Osteopathic Association (MOA), Maine Medical Association (MMA), Maine Hospital Association (MHA) and Maine Academy of Physician Associates (MEAPA). In addition, BOLIM issues a newsletter to its licensees and interested parties three times a year. All three newsletters in 2025 included information about the workgroup and how to participate. The newsletters can be found at <https://www.maine.gov/md/about/newsletter>.

SUMMARY OF WORKGROUP MEETINGS

January 28, 2025 meeting: The discussion involved 13 topics, including board membership and allocation of representation among license types and public members, board structure, and differences in current licensing processes. Workgroup members requested the following additional information: information about states that recently combined boards, if possible, a presentation by the Federation of State Medical Boards (FSMB) about how states handle separate or combined boards, and the experiences of merging boards, and for BOL members to gather feedback from the Maine Osteopathic Association Winter Symposium.

February 26, 2025 meeting: FSMB gave a presentation providing a historical context of medical and osteopathic boards, recent consolidations and key points to consider when contemplating merger of the Maine allopathic and osteopathic boards. Workgroup members asked if a comparison document could be created detailing the processes of both boards. In addition, to facilitate public input, the workgroup suggested that the MMA, the MOA, MEAPA, and the MHA be allocated time to make presentations at the next meeting. Finally,

the workgroup opted to change the meeting time to evening hours to ensure board members who wanted to participate in the workgroup could attend future meetings.

March 26, 2025 meeting: The MOA indicated that its members were concerned that the study process be transparent and objective, preserve DO autonomy and representation, maintain profession specific licensing and disciplinary standards, protect osteopathic continuing education and standards, and that any merger result in financial and operational efficiency. The MOA extended an invitation for BOL members to attend a membership meeting on June 14, 2025.

The MHA provided a slide presentation that listed potential benefits for its members, working with two boards instead of three (currently BOLIM, BOL and the Board of Nursing), more standardization in terms of requirements for licensure, and alignment with other states. The MHA listed a potential barrier as all physicians needing 36 months of postgraduate training.¹ Specifically regarding training programs the MHA listed potential benefits such as aligning licensing requirements for residents, saving time and money by working with only one medical board, and having one set of rules for residents. The MHA listed a potential barrier as limiting the ability of residents to moonlight. Currently DOs can moonlight after 12 months and MDs can moonlight after 24 months.

The MMA indicated that it is neutral on the concept of merger, but stated that it may enhance human and financial resources leading to improved efficiency and responsiveness as well as more fairness in the complaint, investigation and adjudicatory hearing processes. MMA also discussed that there is currently confusion for physicians who are involved in training programs who come from out of state and are only familiar with one of the medical boards. There was also a suggestion that a merger may be beneficial to the Medical Professionals Health Program.

MEAPA indicated it is supportive of a merger and that the current two medical board system, where PAs are licensed by different boards, creates confusion for hospitals, health care facilities and the public.

A comparison document was provided and reviewed by the workgroup. The workgroup asked that a FAQ or fact sheet be created, a dedicated webpage be created, and that budgetary information for BOLIM and BOL be provided for the next meeting.

April 30, 2025 meeting: The dedicated workgroup webpage, <https://www.maine.gov/md/about/merger>, went live on April 11, 2025. Although hosted by BOLIM, a direct link to this website was posted simultaneously on BOL's State website homepage.

Current budgetary and financial information for BOLIM and BOL as well as a draft conceptual budget for a combined board were reviewed. A draft Q & A document was reviewed and workgroup members discussed the request of non-board members to be members of the workgroup. The assistant attorneys general for BOLIM/BOL advised that this was in excess of the boards' existing authority. Workgroup members discussed the process moving forward, as well as a meeting structure to ensure interested persons or entities could make verbal comments at workgroup meetings or submit written comments for review by workgroup members.

The MOA invited members of the workgroup to attend and participate in the MOA Annual Convention. The workgroup agreed that BOL members would attend. In addition, the workgroup determined that the entire May workgroup meeting would be dedicated to receiving public comment and directed that a court reporter be available.

¹ The Legislature recently updated the BOL statute to require a minimum of 36 months of postgraduate training for licensure, which aligns with the BOLIM statute 36 month requirement.

Public Comment was received from MOA lobbyist Charlie Soltan and MOA president Jodie Hermann, DO.

May 28, 2025 meeting: The workgroup received written comments from Gretchen Preneta, PA; Donald Hankinson, DO; Jacey Goddard, DO; Judith Aldrich, DO; and the American Osteopathic Association (AOA). The MOA also submitted a summary of their member survey. Verbal comments were received from MOA staff and MOA Board members, Amanda Mahan, Kathryn Brandt, DO, and Jodie Hermann, DO. In addition, Donald McFadden, DO, a retired physician living in Florida provided verbal comments.

Workgroup members discussed concerns that a merged board would need sufficient representation of specialties to review cases fairly and Ms. MacArthur (BOL staff) offered her comments that the BOL staff's workload is going to become unmanageable, and she needs additional resources to adequately support BOL.

June 25, 2025 meeting: The workgroup discussed a concern expressed during the May meeting that BOLIM and BOL do not receive equal funding. It was explained that the boards are funded by licensure fees and BOLIM, with approximately four times the number of licensees, has a correspondingly higher budget as a result. BOLIM and BOL staff indicated they had recently spoken with staff of merged boards in other states who indicated these mergers had been positive. A BOL board member also indicated they had spoken with a board member of a recently merged board, who also provided positive feedback.

The workgroup discussed that there may be an ongoing and fundamental misunderstanding about the mission of the boards and that there may be a general lack of knowledge of how the boards operate. The workgroup members and staff reiterated that the boards are state agencies tasked with protecting the public rather than with promoting the professions.

The workgroup reviewed information showing the increase in numbers of licensees for both boards over the past ten years and discussed the resulting increased workload that accompanied it. BOL members asked for information regarding what it would cost to adequately staff the BOL to allow it to perform all necessary functions and remain a separate board and what the level of licensing fee increases would be required to generate a budget to support additional staff.

There was brief discussion about the composition of a merged medical board composed of an equal number of allopathic physicians (MDs) and osteopathic physicians (DOs) and how the merged board could also be composed of committees to review complaints and conduct hearings, while ensuring DOs were reviewed and adjudicated by other DOs. Workgroup members indicated they would bring the information about the workgroup discussions to date back to their respective medical boards in July and vote on whether to continue moving forward and take the next step of creating draft legislation with specific details of the merged board's structure, standards, and functions.

James Riley, DO submitted written comment. No verbal comments were submitted.

July 23, 2025 meeting: Workgroup members reported that both BOLIM and BOL voted to continue with the process of studying the feasibility of a merger, although BOL members indicated the BOL had a robust discussion regarding negative feedback from osteopathic physicians.

The workgroup reviewed and discussed draft legislation for a merged medical board prepared by a BOL Board member for the workgroup's consideration. The workgroup reviewed and discussed the draft legislation.

In response to concerns, the workgroup discussed making materials available to the public prior to the workgroup's meetings. Following discussion, the workgroup asked that the information it would review at each meeting be posted to the website approximately one week before each meeting.

Public Comment was received from Jane Carreiro, DO, Dean of the College of Osteopathic Medicine at UNE; Kathryn Brandt, DO, President of the MOA; Robert Piccinini, DO, President of the American Osteopathic Association; Rich Thacker, DO, President Elect of the American Osteopathic Association; Amanda Mahan, Executive Director of the MOA; and Jodie Hermann, DO, Past President of the MOA.

August 27, 2025 meeting: The workgroup reviewed the Kentucky Board of Medical Licensure's committee structure for review of disciplinary matters, in which the board members are divided into two separate committees to review and conduct hearings in disciplinary matters (with the Chair serving on both). Following discussion, the workgroup indicated support for the use of a similar process if BOL and BOLIM merge (without the Chair serving on both).

Workgroup members reviewed estimated budget numbers for the following three scenarios:

- Keeping BOL and BOLIM separate and adding four BOL staff positions to address specific BOL needs. This was estimated to result in renewal fees (paid every two years) increasing approximately \$438 for every DO licensee. The current DO renewal fee is \$525 and this scenario was estimated to require a biennial renewal fee of \$963.
- Keeping BOL and BOLIM separate and adding four staff to BOLIM (not necessary but for comparison only) would result in renewal fees (paid every two years) increasing for every MD license by approximately \$88. The current renewal fee is \$500 and this would bring the renewal fee to \$588.
- Merging the boards and adding four staff (not necessary but for comparison only). This would result in renewal fees increasing for all MDs and DOs by approximately \$74.

The workgroup reviewed the draft statute and discussed several issues, changes, and concerns. Following discussion, the workgroup indicated it would continue its review at the next meeting.

Written comment was provided by Kerrigan Goudreau, DO a second-year medical student at UNE. Verbal comments were provided by Kathryn Brandt, DO; Rich Thacker, DO; John Gimpel, DO, from the National Board of Osteopathic Medical Examiners (NBOME); Teresa Hubka, DO, from the AOA; and John Diefenderfer, DO (Hallowell, ME)

September 24, 2025 meeting: The workgroup continued its review of the draft legislation and noted differences between the draft and BOLIM's current statute. The workgroup asked for licensing data from recently merged boards in the United States and for information about whether such mergers influenced numbers of individuals seeking licensure as DOs. In addition, the workgroup asked for an in-depth, side-by-side comparison of existing BOLIM and BOL statutes with the draft legislation for the merged board at the October meeting.

The workgroup reviewed letters from the National Board of Osteopathic Medical Examiners and a joint letter from the MOA and AOA. Public comment was received from Robert Piccinini, DO; Rich Thacker, DO; and John Diefenderfer, DO.

October 20, 2025 meeting: The workgroup reviewed the previous Q&A document and had no comment. The workgroup reviewed a new Advantages/Disadvantages document and requested some additions. The workgroup also reviewed information that BOL is the only independent Osteopathic Board in the nation that does not have an executive director level administrator.

The workgroup reviewed licensing trends in states that recently merged and discussed that it appeared that no clear conclusions could be drawn from the information.

A side-by-side comparison of the current and proposed statutes was conducted, and concerns were voiced regarding the structure and assigned membership of different committees proposed in the draft legislation.

The workgroup took a straw poll on the latest feeling among workgroup members about merger. Seven of the members present were in favor of recommending potential merger and one member abstained. The workgroup members were asked to bring the information back to the respective boards, along with the information reviewed over the past 10 months, for an official board vote regarding support for the merger and the proposed legislation.

MOA and NBOME provided written comments. Public comment was received from Teresa Hubka, DO; Josie Conte, DO (MOA); and John Diefenderfer, DO.

November 19, 2025 meeting: The workgroup's discussion was devoted to the actions taken by BOLIM and BOL at their respective November regular monthly meetings. In particular, the discussion focused on BOLIM's vote, BOL member reactions to that vote, and BOL's decision to table its vote about whether or not to support merger.

At the November BOLIM meeting, BOLIM voted unanimously in favor of merging the Boards; however, it also voted in opposition to the single issue in the draft legislation requiring an equal number of osteopathic (6) and allopathic (6) physicians (2 board members in favor and 6 opposed to the proposed composition of physician members). As an alternative to that language, and to keep the merger discussion moving forward, BOLIM also voted to propose two options for the composition of the physician board members: (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."

At BOL's meeting immediately following BOLIM's, BOL tabled its vote until after the November 19th workgroup meeting.

At the workgroup meeting, BOL members expressed dismay and frustration over the apparent change in BOLIM's support for equal representation at what was felt to be the last minute of the process. BOL members indicated they did not believe the full BOL would support a merger if the proposed legislation did not include an equal number of osteopathic and allopathic physicians. Following discussion, the workgroup opted to have two members of BOL attend the December 9, 2025, monthly BOLIM meeting to further explain the relevance and importance of the equality of numerical representation of osteopathic and allopathic physicians on any merged medical board.

The MOA and AOA provided written comments. Public comment was received from Robert Piccinini, DO; Kathryn Brandt, DO; and Jodie Hermann, DO.

December 17, 2025 meeting: The workgroup discussed the results of the December monthly meetings of BOLIM and BOL, including the presentation of two BOL members at the regular meeting of BOLIM about the relevance and importance of the equality of numerical representation of osteopathic and allopathic physicians on any merged medical board. The workgroup discussed the vote by BOLIM to recommend the merger with the same number of allopathic and osteopathic physician numbers and the vote by BOL to recommend the merger of the medical boards with the same number of allopathic and osteopathic physician members BOL members

indicated their discussion and vote specifically referenced that they were in favor of merging only if there was an equal number of osteopathic and allopathic physician members on the merged medical board.

The workgroup reviewed the draft statutory language and made several updates including adding language that the current members of BOLIM and BOL would continue to serve on the new Board until the expiration of their terms, changing the composition of the merged medical board membership from 20 to 22 (2 additional public member positions) to allow all current BOLIM/BOL members to remain, and recommending changes to the current “inspection or copying of record” language in the statute.

A more detailed budget for a combined medical board was reviewed, along with current revenue amounts and scenarios for establishing identical licensing fees for MDs and DOs.

A draft report to the legislature was presented and reviewed. Workgroup members made several suggestions and asked that updates from the December 17th workgroup meeting be added.

The workgroup decided to continue meeting on the same schedule in 2026. However, the workgroup will not meet before the report to the legislature is due. The full report to the legislature, with all attachments will be provided to BOLIM and BOL for review at their regular meetings in January 2026 prior to submission.

Public comment was received from Kathryn Brandt, DO; Jodie Hermann, DO; and Laura Gurenlian, DO. In addition, the AOA submitted to the workgroup on the day of the workgroup meeting a letter it had previously submitted to BOL. This was not included in the materials reviewed by the workgroup but will be included in the post meeting materials.

PROPOSED STATUTORY LANGUAGE

During the course of the workgroup’s meetings, draft statutory language was provided by a BOL member and this document became the focus of much of the workgroup’s efforts. As can be seen in the full meeting notes and materials, this draft legislation was updated several times. Although there is still some minor work that needs to be done, the workgroup concluded that the latest draft (attached) provides the best path forward in merging the boards while protecting the public and streamlining processes.

OUTSTANDING ISSUES FOR LEGISLATIVE CONSIDERATION IN THE PROPOSED DRAFT STATUTE

As indicated, the workgroup generally agreed on the draft language. However, there are several areas that require the attention of the Legislature, prior to enactment. These include:

- Term limits – there are currently no term limits for board members, and while the workgroup discussed the benefits to both approaches, it did not reach a clear recommendation on this issue.
- Consider removal of “personal safety” petition from ‘Inspection or copying of record’ (in current law 32 M.R.S. §§ 2600-E and 3300-H). This provision was introduced in 2019 and requires that upon receipt of a FOAA request for an applicant’s or licensee’s files, the board shall compile those files and redact confidential information and then the boards must notify the applicant or licensee, who, upon timely request, may review the compiled redacted record, and may petition the board and request that the board not disclose otherwise non-confidential, public information on the basis that disclosure creates a potential risk to their personal safety or that of a third party. If the board decides the applicant or licensee has not demonstrated such a potential risk to personal safety, the licensee may then initiate an action in Superior Court to obtain an injunction on the basis of the alleged potential risks to personal safety. The Right to Know Committee reviewed this issue in the summer of 2023 and, despite the

board's request, opted to keep the provision on the basis that it was recently added. This section creates additional administrative time and cost burdens for every board FOAA request and invites multi-party and parallel litigation that further increases administrative and financial burdens on the boards, diverting resources from their sole purpose to protect the public health and welfare by ensuring the public is served by honest and competent practitioners through licensing, regulation, and discipline. The boards request the Committee and Legislature consider removal of the novel "personal safety" exception to FOAA, which is time- and cost-intensive and diverts valuable board resources from its clear purpose and existing FOAA obligations.

- Request to raise the statutory cap on licensing fees - BOLIM initial application fees for physicians are higher than BOL initial application fees for physicians, while BOL renewal fees are higher than BOLIM renewal fees for physician licensees. The recommendation is that the fees should be consistent for all physicians licensed by the merged medical board. Although there is no plan to raise licensing fees higher than the current highest amount charged (BOLIM initial fee and BOL renewal fee) a modest increase of \$100 of the statutory cap is recommended to provide room for future fee increases, if needed.
- BOLIM suggestion to modify current requirements regarding the recognition of international medical training – For decades BOLIM has recognized and accepted medical education and post graduate training received in Canada, the United Kingdom and Ireland for its allopathic physician licensees. Obtaining the specific education and post graduate education training documentation can be difficult and time consuming. Is it reasonable to accept as fully trained and qualified anyone from these three areas that are fully licensed and/or registered?
- Interstate Consultative Telehealth Registration – In 2015 the legislature created a consultative telehealth registration (32 M.R.S. § 3300-D (BOLIM)). This registration is extremely limited and only allows a physician not licensed in this state to consult with a physician, or other appropriate health care practitioner (PA or APRN) licensed in Maine related to the care of a patient over whom the Maine-licensed physician, PA, or APRN licensed in Maine retains ultimate authority to diagnose, treat and care for. Given the exponential increase in medical care provided through telehealth nationwide following the pandemic, this registration is confusing to applicants who believe they can see, speak with, and treat Maine patients with this registration, when none of those things are permitted. A significant amount of staff time is spent educating applicants who request this consultative telehealth registration at the application stage and BOLIM has disciplined physicians who have provided services directly to patients even after being educated and attesting they understand that the registration does not permit direct patient care or communication. There are approximately 52 individuals currently holding active registrations under this provision. BOLIM recommends the registration be discontinued and its staff will work with those current registrants to convert the registrations to full licenses or offer the registrants the chance to voluntarily withdraw the registrations.
- Effective Date - An effective date on which the merged board will begin work under the new statute. The workgroup discussed the issue of an effective date and recommends an effective date no earlier than January 1, 2027. If the legislature moves forward with a merger there are technical tasks that need to be completed, such as merging of databases, creation of a website, reconfiguration of office space, and two sets of licensee transitions (telehealth consultative registrants, and the roughly 60 PAs licensed by the BOL), and various other administrative and infrastructure tasks. Upon consideration of these issues, the workgroup thought January 1, 2027 was the best date to allow the practical issues of merger to be addressed to most efficiently and effectively implement the merging of the two boards.
- There are also various other Chapters throughout Maine law that refer to the boards' statutes, that will need to be updated, including Title 5 will need to be amended to establish the merged Board and provide for the board member per diem rates. BOLIM staff will be happy to work with the Committee to provide a list of the known provisions that will also need to be updated at the time of enactment of a merged board statute.

BUDGET

A draft budget has been prepared and is attached to this report. It contains a regular fiscal year budget, based on FY27 figures as well as a budget for one-time costs. It is expected that the one-time costs can come out of reserves with no additional costs to licensees.

BOL PHYSICIAN ASSOCIATES LICENSE TRANSITION

Physician Associates (PA) are currently licensed by both boards. Because the current licensing database works independently for both boards, a PA licensed with BOLIM may have the same license number as a PA licensed by BOL. We believe we can easily transfer expired and lapsed licenses. However, the approximately 60 PAs actively licensed by BOL will likely need to obtain new license numbers. Staff will work to assist these licensees with in as seamless a manner as possible to ensure continuity of licensure and patient care. However, this may impact their credentialing, privileging at facilities and insurance enrollments.

Sincerely,



Timothy Terranova
Executive Director
Board of Licensure in Medicine



Rachel MacArthur
Executive Secretary
Board of Osteopathic Licensure

Appendix

Draft Statute	11
Workgroup Budget Information	41
2025 Workgroup Notes and Materials	
January 2025.....	44
February 2025	48
March 2025.....	63
April 2025	79
May 2025	88
June 2025	146
July 2025.....	158
August 2025.....	188
September 2025.....	232
October 2025	338
November 2025.....	404
December 2025	445

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 associate 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. **General business.** "General business" means all board actions conducting the public business, with exception of disciplinary investigations, complaints, and adjudicatory hearings resolving disciplinary matters involving licensees or applicants,
6. **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 associate, advanced practice nurse, nurse, physical therapist, occupational therapist, speech therapist, social worker, nutritionist, psychotherapist, counselor or other licensed professional.
7. **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.
8. **Osteopathic Physician.** "Osteopathic Physician" means a physician who graduated from medical school with a DO degree.
9. **Physician.** "Physician" means an allopathic or osteopathic physician or surgeon licensed by the Board.
10. **Physician Associate.** "Physician Associate" means a physician associate licensed by the Board.
11. **Practice Agreement.** "Practice agreement" means a document agreed to by a physician associate who is the principal clinical provider in a practice and a physician that states the physician will be available to the physician associate for collaboration or consultation.

- 12. 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, 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.
- 13. 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.
- 14. 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 associate 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 or appropriately licensed by and practicing within their legal scope of practice under the authority of another Maine licensing board.

§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 **XXX**, 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 22 members appointed by the Governor as follows:

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

- 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. Six 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 consumer or patient advocacy groups, 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.
 - C. Investigative Committees. Five members of the investigative committee constitute a quorum for all investigative committee meetings
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 as physicians or physician associates 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;
3. **Licensing and standards.** The power to license and to set standards of practice for physicians and surgeons and physician associates 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 10 8003-A and Title 5, section 9060, for the production of documents, records and the testimony of witnesses in the course of an investigation or an adjudicatory hearing, and this authority applies to any stage of an investigation and is not limited to an adjudicatory proceeding, and during investigation this power is delegated to Investigative Committees of the Board, or outside of regular meetings of the Committees, 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 17 and 18, the power to employ and prescribe the duties of other personnel as the board determines necessary. Except as prescribed in subsection 17, 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 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 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.

§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 opportunity to request that any records or information not be disclosed on the basis that such information is confidential by law. 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 list from the applicant or licensee specifically identifying those records that are confidential by law or contain information that is confidential by law. Upon timely submission of a claim that any record or information is confidential, the Board, or if delegated, the Executive Director, will make a written determination

whether the information is confidential by law and provide that written response to the licensee or applicant.

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.
4. 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, complaint or investigation 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 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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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 PA Compact shall be no higher than the application fee for a physician associate license.
 - C. Fees for the renewal of a PA Compact privilege shall not exceed \$350.

§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 associate under this chapter. The board shall request a background check for each licensed physician associate 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 associate 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 associate 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:

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

- 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 or be licensed and/or registered to practice medicine according to the laws and rules of Canada, the United Kingdom, or Ireland. 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.
- 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.

§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 XXXX, 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.

§XXXX. Renewal of PA Compact Privilege

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

All PAs exercising compact privileges in Maine must renew those compact privileges timely and consistent with all requirements of the PA Compact, Title 32 Chapter 145-A, PA Compact Rules and the Participating State which issued their Qualifying License and must pay all fees required by the Board.

§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.

§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 eleven (11) members, each investigative committee to include 3 allopathic physicians, 3 osteopathic physicians, 2 physician associates and 3 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 taken from among one of the two investigative committees, 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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

- and investigation of the licensee, or applicant for licensure, whose case is being adjudicated.
- B. Adjudicatory hearings held by adjudicatory hearing panels shall be conducted consistent with Title 5, chapter 375, subchapter 4.
 - 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 rules.

§XXXX. Complaints; reports; investigations

Procedure. The board, acting through the investigative 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, the licensee, or a patient related to the complaint, 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 one of the investigative committees 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 and any issue arises during the application review that may constitute grounds for discipline, the board, acting through the investigative committee, may investigate the professional or criminal 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 one of the investigative committees for review. Following review, the investigative 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 licensee to submit to a mental or physical examination by a physician or another person designated by the board. Failure of a licensee 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 licensee affected under this paragraph must, at reasonable intervals, be afforded an opportunity to demonstrate that the licensee 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 licensee 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. The board may suspend or revoke a license or privilege issued by the board pursuant to Title 5, section 10004. In addition to the powers under Title 10, section 8003, subsection 5, the board may suspend, revoke or refuse to issue or renew a license or privilege, or impose license or privilege restrictions, conditions, and periods of probation based on the following grounds for discipline:

- 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:
 - 1. 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
 - 2. 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;

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

- 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 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 associates 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 Medicine, 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 licensee 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 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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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.
11. The appointments of current Board Members of both the Board of Licensure in Medicine and the Board of Osteopathic Licensure shall carry over and all sitting members appointed by the Governor at the effective date of the merger shall be serve on the Board of Medicine until their existing appointment terms expire.

§XXXX. Effective date. This Act takes effect on January 1, 2027.

	BOLIM	BOL	One-time	On-going	Combined
Licensees	9,865	1,951			11,816
Board Members	11	11			22
Reduction					
Employees	12	2	-	-	14
Existing staff	12	2	-	-	14
<i>New staff, none</i>			-	-	-
Cash Balance	\$6,159	\$1,029	-	-	\$7,188
<i>*projected at end of FY26</i>					
Revenues	\$2,546	\$427	-	-	\$2,973
Transfers, financial	(\$191)	(\$29)	-	-	(\$220)
PERSONAL SERVICES	\$1,630	\$202	-	\$13	\$1,845
Existing staff	\$1,669	\$202	-	-	\$1,871
<i>Stipends increase for Osteo Board</i>			-	\$13	\$13
ALL OTHER	\$1,121	\$260	\$195	\$247	\$1,823
Contracts	\$353	\$18			\$371
<i>Additional contracts for evaluators</i>				\$25	\$25
AAG & SESC	\$365	\$171			\$536
<i>Additional AAG services, need 2 full-time</i>				\$194	\$194
Travel	\$27	-			\$27
<i>Increase travel for Osteo Board members reimb</i>				\$5	\$5
Rents	\$94	\$16			\$110
<i>Office Space renovation/reconfig</i>			\$20		\$20
General Ops	\$88	\$21			\$109
<i>Renaming/rebranding</i>			\$25		\$25
<i>Reduction in association costs (redundant)</i>				(\$4)	(\$4)
Tech	\$131	\$17			\$148
<i>Additional laptops for 9 Board members</i>				\$27	\$27
<i>Merging of databases</i>			\$130		\$130
<i>New website</i>			\$20		\$20
Office & supplies	\$13	\$2			\$15
Other Expenses	\$19	\$4			\$23
STACAP	\$31	\$11			\$42
Total Expenditure	2,751	462	195	260	3,668

Budgeted vs. Actual Revenue - *Revenue amounts in \$K				
	BOLIM			BOL
2021				
Budgeted	\$1,673			\$247
Actual	\$2,296			\$370
2022				
Budgeted	\$1,906			\$349
Actual	\$2,509			\$415
2023				
Budgeted	\$1,901			\$365
Actual	\$2,701			\$433
2024				
Budgeted	\$2,288			\$387
Actual	\$2,756			\$491
2025				
Budgeted	\$2,395			\$371
Actual	\$2,937			\$502

Possible Revenue Changes *Estimated Figures Only Using licenses issued in 2024*						
	Fee	Issued	Amount			
Current						
BOLIM Initi	\$700	1000	\$700,000			
BOL Initial	\$350	150	\$52,500			
BOLIM Ren	\$500	4000	\$2,000,000			
BOL Renew	\$525	1000	\$525,000			
Total				\$3,277,500		
Possibility 1						
BOLIM Initi	\$600	1000	\$600,000			
BOL Initial	\$600	150	\$90,000			
BOLIM Ren	\$500	4000	\$2,000,000			
BOL Renew	\$500	1000	\$500,000			
Total				\$3,190,000		
Possibility 2						
BOLIM Initi	\$600	1000	\$600,000			
BOL Initial	\$600	150	\$90,000			
BOLIM Ren	\$525	4000	\$2,100,000			
BOL Renew	\$525	1000	\$525,000			
Total				\$3,315,000		
Possibility 3						
BOLIM Initi	\$350	1000	\$350,000			
BOL Initial	\$350	150	\$52,500			
BOLIM Ren	\$525	4000	\$2,100,000			
BOL Renew	\$525	1000	\$525,000			
Total				\$3,027,500		
Possibility 4						
BOLIM Initi	\$700	1000	\$700,000			
BOL Initial	\$700	150	\$105,000			
BOLIM Ren	\$500	4000	\$2,000,000			
BOL Renew	\$500	1000	\$500,000			
Total				\$3,305,000		

Board of Licensure in Medicine - Board of Osteopathic Licensure Workgroup
January 28, 2025
12:00 p.m. – 1:26 p.m.

Board Members - In Person

Public Member Lynne Weinstein (BOLIM)
John Brewer, DO (BOL)
Melissa Michaud, PA (BOL)
Public Member Peter Michaud, JD, RN (BOL)
Public Member Dennis Smith, Esq. (BOL)
Public Member Mary-Anne Ponti, RN, DBA (BOL)

Board Members - Remote

Maroulla Gleaton, MD (BOLIM)
Christopher Ross, PA (BOLIM)
Anthony Ng, MD (BOLIM)
David Flaherty, PA (BOLIM)
Public Member Jonathan Sahrbeck (BOLIM) (excused at 1:00 p.m.)
Noah Nesin, MD (BOLIM)

Board Staff Present

Executive Secretary Rachel MacArthur (BOL)
Executive Director Timothy Terranova (BOLIM)
Assistant Executive Director Valerie Hunt (BOLIM)
Medical Director Paul Smith, MD (BOLIM)
Administrative Assistant Maureen Lathrop (BOLIM)

Legal Counsel - Remote

AAG Jennifer Willis (BOLIM)
AAG Lisa Wilson (BOL)

I. Introduction of Board Members and Staff

II. Discussion of Board Members' Suggested Topics

A. Representation - MD/DO/PA/Public

Workgroup members agreed that there needs to be fair representation of allopathic and osteopathic physicians, physician assistants and public members.

B. Board structure including number of members

A larger Board would allow for dividing tasks and improving efficiency. It may also allow for a better representation of specialties. If the Board size is large enough separate committees could be created – one to review complaints and one to handle adjudicatory hearings. This would remove the argument of bias because the same Board members would not investigate and adjudicate complaints. The committees would need statutory authority to dismiss and adjudicate complaints, rather than the full Board. The number of Board members would need

to be sufficient to include allopathic, osteopathic, physician assistant and public member representation on each committee.

Mr. Terranova suggested that five allopathic physicians, five osteopathic physicians, three to four physician assistants and three to four public members may be fair representation and a sufficient number of members to allow for the creation of committees.

C. Staffing/salaries

Mr. Terranova stated that merging the Boards would not require a reduction in staff size. BOLIM has a current open position that would allow for retention of staff of both Boards and ensure adequate staffing.

D. Educational sessions to learn differences

Mr. Terranova asked if the workgroup would be interested in hearing from the Federation of State Medical Boards (FSMB) regarding the Model Practice Act and how different boards conduct business.

E. Experiences of other states

Mr. Terranova reported that he requested information from New Mexico, which merged two years ago, and West Virginia, which attempted to merge last year, but had the bill vetoed by the governor.

F. How will cultures be valued in change

G. Name of Board

Ms. Michaud suggested The Maine Board of Medicine as a potential name. Workgroup members agreed that the name is inclusive of allopathic and osteopathic physicians and physician assistants.

H. Transparency

I. Meeting dates and times

This matter was briefly discussed. The structure of the Board will affect frequency of meetings. Committees to review complaints and adjudicate cases may need to meet monthly. The full Board may need to meet less frequently depending on the need for review of administrative matters.

J. Difference in approach to care and investigations

Mr. Smith has experience with both BOLIM and BOL complaint processes. He noted that the processes are similar but noted that BOLIM has multiple staff members dedicated to complaints and investigations, while BOL has one full time staff member and one part time

staff member. Mr. Smith noted that BOL is licensing more physicians and receiving more complaints. More staff resources are needed.

Mr. Terranova briefly described BOLIM complaint unit staff and their duties:

- The Complaint Coordinator is responsible for supervising complaint unit staff, arranging expert reviews and physician evaluations, and monitoring licensees under consent agreement
- The Consumer Assistance Specialist is the point of contact for the public and assists with preparing complaints for Board review (this position is shared with BOL)
- The Investigative Secretary is responsible for requesting records and complaint related material, and managing all complaint related materials submitted
- The Medical Director reviews incoming medical records related to complaints and highlights specific records relevant to complaints prior to Board review.

Both Boards have assigned legal counsel and utilize an investigator with the AG's Office when necessary.

K. Disparities in licensing

BOL statute requires that the Board review and vote to approve all license applications. The BOL does not require applicants to complete a jurisprudence exam.

BOLIM relies on delegation to approve license applications with no issues. The Assistant Executive Director reviews and approves license applications with no affirmative responses to the personal data questions on the application, except for hospital privileges and malpractice. The Board Secretary reviews applications with affirmative responses to the personal data questions and may approve the application or refer to the full Board.

BOLIM has a licensing supervisor and two licensing specialists who split the incoming applications based on the last name of applicant with one handling A-L and the other handling M-Z.

L. What is the reason for change

Workgroup members discussed the need to be clear about the reason for merging the Boards and agreed enhanced public protection is the primary reason. Mr. Smith expressed concern that current staffing levels may affect BOL's ability to carry out its mission. Dr. Gleaton pointed out that merging into one Board reflects how the practice of medicine has evolved to be collaborative.

M. Updating terminology

III. Next Steps

Mr. Smith noted that as discussions continue the workgroup will need to think about having rules in place when the Boards merge and how the merger will affect the IMLC and PA Compacts.

Workgroup members agreed on monthly 1 ½ hour virtual meetings to continue discussions. BOLIM staff will send a poll to determine the next meeting date and time.

The workgroup would like to have the following information prior to the next meeting:

- A list of states that recently merged allopathic and osteopathic boards (within the last ten years)
- Feedback from state boards regarding roadblocks encountered. Mr. Terranova reported that he is waiting for feedback from New Mexico and West Virginia.
- How did recently merged boards choose a name and how was the new name received by licensees
- FSMB presentation on model practice act
- Provide the LD number for legislative resolve once assigned
- Dr. Brewer noted that the Maine Osteopathic Association Winter Symposium will be held in the next couple of weeks. He will ask that feedback coming out of the meeting regarding potential merger of the Boards be shared.

I. Adjourn 1:26 pm

Board of Licensure in Medicine - Board of Osteopathic Licensure Workgroup
ZOOM meeting
February 26, 2025
12:00 p.m. – 1:15 p.m.

Board Members Present

Public Member Lynne Weinstein (BOLIM)
Maroulla Gleaton, MD (BOLIM)
Renee Fay-LeBlanc, MD (BOLIM) – arrived at 1:10 p.m.
Melissa Michaud, PA (BOL)
Public Member Peter Michaud, JD, RN (BOL)
Public Member Dennis Smith, Esq. (BOL) – excused at 1:10 p.m.
Public Member Mary-Anne Ponti, RN, DBA (BOL)
John Brewer, DO (BOL)

Board Staff Present

Executive Secretary Rachel MacArthur (BOL)
Executive Director Timothy Terranova (BOLIM)
Assistant Executive Director Valerie Hunt (BOLIM)
Administrative Assistant Maureen Lathrop (BOLIM)

Legal Counsel Present

AAG Jennifer Willis (BOLIM)

Dr. Humayun Chaudhry, CEO of the Federation of State Medical Boards, gave a presentation (slides attached) providing a historical context of medical and osteopathic boards, recent consolidations and key points to consider when contemplating merger of the Maine medical and osteopathic boards. Ideally, allopathic and osteopathic professions should have equal representation on the board, and the opportunity to serve in leadership roles and on committees. Ultimately the purpose of the board is to protect the public and the boards should consider if a merger will support that mission.

Dr. Chaudhry responded to questions from Board members and concluded his presentation at 12:41 p.m.

Ms. Weinstein stated that it might be helpful for medical board members to observe an osteopathic board meeting and vice versa to learn more about similarities and differences in processes and functions.

Board members discussed that it may be helpful for staff to create a comparison document detailing the processes of both boards. Mr. Terranova and Ms. MacArthur will work on creating a comparison document to share for the next workgroup meeting.

Mr. Michaud asked if the AAGs could create a comparison document for the medical practice acts and rules of the two boards so board members can understand differences? AAG Willis will work on creating a comparison document to share with the workgroup.

Mr. Terranova suggested inviting the Maine Medical Association, Maine Osteopathic Association, Maine Academy of Physician Assistants and the Maine Hospital Association to make brief presentations at the next workgroup meeting to help identify areas of concern or confusion and request their assistance in providing information to their members. Workgroup members agreed this would be helpful.

Mr. Terranova also suggested creating a survey to send out to licensees. Workgroup members discussed that it was early in the process, and it would be more helpful to hear from the associations before considering a larger survey.

Ms. Ponti suggested that creating an educational fact sheet after hearing concerns from the associations

may be helpful.

Board members asked if there was feedback from the Maine Osteopathic Association Winter Symposium. Dr. Brewer stated there was some negative feedback from a small group of attendees.

Mr. Terranova noted that a discussion regarding recent board mergers is planned at the upcoming Administrators in Medicine meeting in April and he will report back to the workgroup.

Mr. Terranova commented that a member of the osteopathic board is interested in attending workgroup meetings but is unable to attend on Wednesdays due to his work schedule. Workgroup members suggested that adding some options for evening meetings might allow more Board members to attend. BOLIM staff will send a poll to determine the next meeting date and time.

Adjourn 1:15 pm



Considerations for Consolidation of State Medical and Osteopathic Boards



Historical Context Independent State Osteopathic Boards

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STATE	1910	1915	1924	1939	1967	2022	2025
Arkansas	X	X	X	X	X		
Arizona					X	X	X
California			X	X	X	X	X
Connecticut	X	X	X	X			
Florida	X	X	X	X	X	X	X
Georgia	X	X	X	X	X		
Hawaii				X	X		
Idaho	X	X	X	X	X		
Iowa			X	X			
Kansas				X			
Louisiana	X	X	X	X	X		
Maine			X	X	X	X	X
Maryland			X	X	X		
Michigan	X	X	X	X	X	X	X
Minnesota	X	X	X	X			
Missouri	X	X	X	X			
Montana	X	X	X	X	X		
Nebraska	X	X	X	X	X		
New Mexico	X	X	X	X	X		
Nevada				X	X	X	X
North Carolina	X	X	X	X	X		
North Dakota	X	X	X	X	X		
Oklahoma			X	X	X	X	X
Pennsylvania	X	X	X	X	X	X	X
Rhode Island		X	X		X		
South Carolina				X	X		
South Dakota	X	X	X	X			
Tennessee	X	X	X	X	X	X	X
Utah				X	X	X	
Vermont	X	X	X	X	X	X	X
Washington				X	X	X	X
West Virginia				X	X	X	X
	18	19	24	30	24	13	12

Current Separate Boards

- Arizona
- California
- Florida
- Maine
- Michigan
- Nevada
- Oklahoma
- Pennsylvania
- Tennessee
- Vermont
- Washington
- West Virginia



Recent Consolidations

- **New Mexico Medical Board (2021)**
 - Merged the New Mexico Board of Osteopathic Medicine with the New Mexico Medical Board, keeping the title New Mexico Medical Board
 - The board consists of 9 members: 8 physicians (at least 2 MDs and 2 DOs), 1 PA, and 2 public members
- **Illinois State Medical Board (2022)**
 - Merged the Medical Licensing Board and Medical Disciplinary Board into the Illinois State Medical Board
 - The board consists of 17 members: 8 MDs, 2 DOs, 2 DCs, 2 PAs, and 3 public members
- **Utah Medical Licensing Board (2024)**
 - The Utah Physicians and Surgeons Licensing Board was renamed as the Utah Medical Licensing Board and absorbed the Utah Osteopathic Surgeons Licensing Board and the Utah Physician Assistant Licensing Board.
 - The board consists of 15 members: 7 MDs and 2 DOs; 3 PAs; and 2 public members.

Introduced Consolidations

- Nevada (Pending Legislation – SB 78 – 2025)
 - Would merge the Board of Medical Examiners and the State Board of Osteopathic Medicine and rename it the Nevada Medical Board
 - Would consist of 11 members: 4 MDs, 4 DOs, 1 PA, 1 respiratory therapist, and 1 public member

Failed Consolidations

- Oklahoma (2015)
- Arizona (2016)
- West Virginia (2024)
 - Vetoed on March 27, 2024 by the West Virginia Governor, the bill would have subsumed the operations of the Board of Osteopathic Medicine under the unified West Virginia Board of Medicine, adding osteopathic physicians and genetic counselors to the purview of the Board.



FSMB Policies

- *A Guide to the **Essentials** of a Modern Medical Practice Act* was first issued in 1956
- ***Elements** of a State Medical and Osteopathic Board* was first issued in 1989
- Over the years, the **Essentials** and **Elements** guides underwent numerous revisions to respond to changes in medical education, the practice of medicine, evolving responsibilities of boards, and to assist member boards to be consistent with best practices in the interests of public protection and patient safety.
- In 2018, *Guidelines for the Structure and Function of a State Medical and Osteopathic Board* ("**Guidelines**") combined the **Elements** and **Essentials** guides, and contain the principles of state medical board responsibility, duty, empowerment, and accountability that the initial documents outlined, as well as detailing the essential components for the structure and function of a state medical board.
- **Guidelines** was updated in 2021 and again in 2024 to reflect current best practices



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



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

Adopted by FSMB House of Delegates, April 2024

INTRODUCTION

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



FSMB Guidelines – Duty, Responsibility, and Power

“In some states, responsibility for licensing and disciplinary functions is divided between two separate Boards. In others, Boards are subject to supervision or, in some cases, complete control by larger administrative or umbrella agencies. In a few states, the Board is simply an advisory body.

In most states, the Board regulates both allopathic and osteopathic physicians; in others, separate boards exist. And in some states, narrow constitutional restrictions inhibit effective Board funding... The following section proposes a true working board with real and effective power and support, a proposal some states are much better prepared to implement than others...



FSMB Guidelines – Duty, Responsibility, and Power

...The section also reflects those principles the authors consider to be basic to the operation of any accountable medical board, regardless of the administrative structure of the state, the size or distribution of the physician population being regulated, the form of legislation required for funding, or the title of the body to which responsibility and power for regulation have been entrusted. It may be drawn upon by both allopathic and osteopathic boards, making appropriate adaptations in the area of Board membership. Larger administrative agencies can use it to better assess their own structures and functions and to explore the broader roles their medical boards might play in meeting public expectations.”



FSMB Guidelines – Board Membership

Composition and Size

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



FSMB Guidelines – Examinations

The Medical Practice Act should provide for the Board's authority to approve an examination(s) of medical knowledge satisfactory to inform the Board's decision to issue a full, unrestricted license to practice medicine and surgery in the jurisdiction.

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

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

Thank You! Questions?



**U.S. Medical Regulatory Trends &
Actions Report**



**FSMB Policies &
Regulatory Resources**



**Advocacy Network
Newsletter**

Board of Licensure in Medicine - Board of Osteopathic Licensure Workgroup
ZOOM meeting
March 26, 2025
5:31 p.m. – 7:23 p.m.

Board Members Present

Public Member Lynne Weinstein (BOLIM)
Renee Fay-LeBlanc, MD (BOLIM)
Anthony Ng, MD (BOLIM)
Maroulla Gleaton, MD (BOLIM)
Melissa Michaud, PA (BOL)
Public Member Peter Michaud, JD, RN (BOL)
Public Member Dennis Smith, Esq. (BOL)
Public Member Mary-Anne Ponti, RN, DBA (BOL)
John Brewer, DO (BOL)
Christine Munroe, DO (BOL)
Lisa Ryan, DO (BOL)
Paul Vinsel, DO (BOL)

Board Staff Present

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

Legal Counsel Present

AAG Jennifer Willis (BOLIM)
AAG Lisa Wilson (BOL)

Following roll call of board members present, Mr. Terranova gave the workgroup an update on LD805. Following the recent work session, the committee voted the bill unanimously ought not to pass. However, they also instructed that a letter be sent to the boards directing them to continue their work and to present their findings to the committee in January 2026.

Following the February workgroup meeting, the Maine Osteopathic Association, Maine Medical Association, Maine Hospital Association and Maine Academy of Physician Associates were invited to give presentations to the workgroup to identify areas of concern or confusion among their members.

Maine Osteopathic Association (MOA) Presentation - Amanda Mahan, Executive Director, Kathryn Brandt, DO and Isabella Askari, DO

Ms. Mahan indicated that the MOA, as well as the national organization American Osteopathic Association, are in support of a transparent data driven approach to evaluate merger of the two Boards. She shared key areas of concern for the MOA and its members.

1. Ensuring an Objective & Transparent Study Process

Ms. Mahan encouraged the workgroup to involve stakeholders, including licensees and members

of the public, in the study process. A merger of the two boards will have an impact upon licensees and their patients. To ensure transparency, she suggested that agendas, meeting minutes and meeting material be shared. Ms. Mahan also noted that the MOA would be interested in having a formal workgroup member.

2. Preserving DO Autonomy and Representation

Ms. Mahan noted that their members have emphasized the need for equal representation on a merged board to preserve the DO perspective and distinct approach to patient care. Ms. Mahan shared statistics regarding the growth of the osteopathic profession.

3. Maintaining Profession-Specific Licensing & Disciplinary Standards

MOA members have expressed concern that merging the boards must not compromise profession-specific disciplinary standards or evaluation by peers who recognize osteopathic principles and techniques.

4. Protecting Osteopathic Continuing Education and Standards

Ms. Mahan indicated that members have emphasized that osteopathic-specific continuing medical education that aligns with their training must be preserved.

5. Financial & Operational Efficiency

Ms. Mahan noted that the assumption that a merger would improve efficiency must be proven, not presumed. A merger should only proceed if it demonstrably improves efficiency without compromising standards.

In conclusion, Ms. Mahan stated that MOA members recognize that administrative efficiencies could be gained with a single board. However, their overwhelming concerns center on representation, protection of osteopathic practice standards, and the long-term impact of such a significant change.

The MOA is committed to keeping members informed and can gather feedback to share with the workgroup.

Ms. Mahan extended an invitation for BOL leadership to attend the next membership meeting on June 14th.

Dr. Brandt provided a history of how osteopathic physicians had been sidelined in the medical profession.

Dr. Askari indicated that collaboration with stakeholders is key.

Maine Hospital Association (MHA) – Slide Presentation

Due to a conflict, the MHA was unable to have a representative participate in the meeting. The MHA prepared a slide presentation based on a poll of members. The MHA noted the following potential benefits and barriers from a hospital operations perspective:

Potential Benefits:

- Dealing with two boards for provider rules, requirements and reporting instead of three (MD/DO/Nursing)
- More standardization in terms of requirements for licensure
- Alignment with most other states

Potential Barriers:

- All physicians would require 36 months of GME training for licensure

The following potential benefits and barriers from a residency training program perspective were noted:

Potential Benefits:

- Aligns all residents in terms of licensing
- Save time and money by only needing to get training licenses from one board
- Similarly, it assists program directors by only needing one set of rules for residents

Potential Barriers:

- May limit ability of residents to moonlight until after 36 months of training. Currently DO's can moonlight after 12 months of training.

Mr. Terranova clarified that a merger of the boards would not automatically make licensing requirements the same for MDs and DOs. Changes to licensing requirements would involve a change in existing statutes.

Mr. Michaud indicated that the BOL has discussed changing licensing requirements for DOs to require a 36-month residency training program.

Maine Medical Association (MMA) Presentation – Andrew MacLean, CEO, Jim Jarvis, MD, R. Scott Hanson, MD and Anne Sedlack

Mr. MacLean shared that the MMA represents more than 4,000 physicians, residents and medical students in the state – including licensees of both BOLIM and BOL. He indicated that the MMA is neutral on the concept of merging the boards, but did state that a merger may enhance human and financial resources leading to enhanced efficiency and responsiveness as well as more fairness in the complaint, investigation and adjudicatory processes.

Dr. Jarvis discussed the GME process and indicated there is often confusion for physicians and staff who come from out of state and are familiar with only one board.

Dr. Hanson indicated that a merger of the boards may be beneficial to the Medical Professionals Health Program.

Maine Academy of Physician Associates (MEAPA) Presentation – Kathleen Moneghan, PA

Ms. Moneghan stated that MEAPA is supportive of a board merger. Currently having two licensing boards causes confusion for hospitals and health care facilities as well as the public seeking to verify a PA's licensure status. MEAPA can provide information regarding a potential board merger to its members and assist the workgroup by obtaining information helpful to its discussions.

BOLIM – BOL Structure and Processes

Mr. Terranova reviewed a comparison of BOLIM and BOL structures and processes with the workgroup, the majority of which are similar.

The workgroup discussed differences in rules, licensing requirements and review of license applications. Following discussion, workgroup members requested the following information:

Ms. Michaud requested that a copy of BOLIM's jurisprudence exam and study materials be shared with workgroup members. BOL does not require a jurisprudence exam for its licensees.

Dr. Gleaton requested a comparison of BOL's Chapter 16 Prescribing and Treatment of Self and Family Members Rule and BOLIM's guidance on prescribing for or treating self or family.

Workgroup members had a brief discussion regarding the number of licensing applications, complaints and investigations each board reviews monthly. In addition, there was discussion regarding the potential to create separate committees – one to review complaints/investigations and one to conduct adjudicatory hearings with a merged board with more board members.

Mr. Terranova informed the workgroup that the FSMB has a department dedicated to collecting and analyzing data. The FSMB is willing to assist the boards in designing a survey to send to licensees as well as analysis of the data.

Next Steps

The workgroup would like to see BOLIM and BOL budget and financial information at the next meeting.

Board staff will work on creating a fact sheet for review at the next meeting. Fact sheets can be distributed to the associations periodically for distribution to their members.

Board staff will work with IT to add a page to the BOLIM and BOL websites to post information regarding workgroup meetings.

The next workgroup meeting will be held on April 30th beginning at 5:30 p.m.

Adjourn 7:23 pm



MOA Executive Committee

Jodie Hermann, D.O., MBA
President

Kathryn Brandt, D.O.
President-Elect

Josephine Conte, D.O.
Treasurer

Brian Kaufman, D.O.
Immediate Past President

MOA Board of Directors

Isabella Askari, MPH, D.O.

Lynette Bassett Willard, D.O.

Karen Benezra, D.O.

John Diefenderfer, D.O.

Breanna Glynn, D.O.

Jerald Hurdle, D.O.

Audrey Okun-Langlais, D.O.

K. Emily Redding, D.O.

Tristan S. Reynolds, D.O.

Heather A. Sharkey, D.O.

Mary Yee, D.O.

UNECOM Student Representative
Keely Thomas, OMS-I

Resident Representative
Andrew Freedman, D.O.

MOA Staff

Amanda Mahan,
Executive Director

MOA Comments on the BOL/BOLIM Workgroup Feasibility Study

March 26, 2025

Good evening, and thank you for the opportunity to speak. I am here on behalf of the **Maine Osteopathic Association (MOA)**, representing over **400 practicing osteopathic physicians** as well as an ever-growing number of osteopathic medical student members, dedicated to high standards of medical practice, patient care, and public health.

The discussion around merging the **Maine Board of Osteopathic Licensure (BOL)** and the **Maine Board of Licensure in Medicine (BOLIM)** is not a new one, and it's true that our members—many of whom have long histories in the medical practice environment in Maine—have shared concerns. The MOA and our national partner, the **American Osteopathic Association (AOA)**, support a **transparent, and data-driven approach** that fully evaluates the impact of such a merger before any decisions are made.

Key Concerns & Considerations

1. Ensuring an Objective & Transparent Study Process

This process must be **thorough, data-driven, and free of predetermined conclusions**. Many members fear that this discussion is happening behind closed doors and could lead to a decision that diminishes the distinct role of osteopathic medicine in Maine.

One long-time DO shared, *"We have seen promises of goodwill before, only to find ourselves sidelined. Any commitments to preserving osteopathic representation must be in writing, not just spoken assurances."*

Stakeholders, including licensees and the public, **must have opportunities to engage** throughout the study process to ensure true transparency. While patient protection is the primary role of the licensing boards, we believe strongly that licensees deserve to be a part of considering a merger like this that would affect them along with their patients.

While we have been allowed to attend meetings, this is our first true opportunity to share our input, and we hope it's not the last! **We would love to have a formal representative on the workgroup**, see workgroup meeting minutes, drafts circulated

for public comment, etc in the future to ensure this process is easy to follow for the public.

2. Preserving DO Autonomy & Representation

Our members repeatedly emphasize the need for **equal representation** on any merged board. Without explicit safeguards, there is concern that DO perspectives will be overshadowed.

A member stated, “One only needs to look at history. The DO voice could be drowned out, and decision-making could become one-sided. This is not paranoia; this is experience.”

DOs have a **distinct approach to patient care** that must be preserved, particularly in regulatory decision-making. And the Osteopathic profession has grown exponentially in the last two decades – with this trend undoubtedly to continue. Now nearly 30% of all medical students are training in osteopathic programs. And in Maine DO licensure applications are increasing; approx. 1 in 5 Maine physicians is a DO (by my figures of the publicly available data) and 25% of family physicians are DOs.

3. Maintaining Profession-Specific Licensing & Disciplinary Standards

Since 1973, the **BOL has ensured that DOs are evaluated by true clinical peers** who understand osteopathic philosophy and practice.

One physician recounted their experience with a complaint, saying: “I was distressed, but I was reassured knowing that my case would be evaluated by professionals who understood osteopathic principles. This is essential for fair oversight.”

Merging the boards **must not compromise profession-specific disciplinary standards** or the ability to be judged by true peers who recognize osteopathic principles and techniques.

4. Protecting Osteopathic Continuing Education & Standards

Our members emphasize that any changes **must preserve access to osteopathic-specific continuing medical education (CME)** and standards and guidance that align with our unique training.

This is a fundamental issue, as one member put it: *“If we merge, what guarantees do we have that osteopathic education won’t slowly disappear?”*

5. Financial & Operational Efficiency

The assumption that a merger would improve efficiency **must be proven, not presumed**. A merger should only proceed if it demonstrably improves efficiency without compromising standards.

In General, we see some key operational areas for improvement regarding the BOL (according to feedback we have received):

- Communication (regarding licensure status, applications, complaints, etc), timely posting of information, (Agendas, Meeting links, etc)
- Improvement to communication and fairness for the individual licensee (and their representation) in the complaint and disciplinary process.
- Transparency of board member nominations and appointments (inconsistent information and communication)

MOA's Role in Supporting the Workgroup

MOA is committed to **keeping our members informed and engaged**. We have and will continue to:

- Provide ongoing updates in newsletters and communications.
- Invite BOL leadership to our **Membership Meetings (next is on June 14th** at the Samoset) to engage directly with DOs.
- Host meetings or surveys to **gather DO perspectives and relay them to this workgroup**.

If there are specific aspects of this study that require feedback, **we are more than willing to help facilitate that engagement**.

And as we have stated time and time again, we **welcome the opportunity to be a formal part of this work as a member of the workgroup**.

Conclusion & Recommendations

Our members recognize that administrative efficiencies could be gained with a single board. However, their overwhelming concerns center on **representation, protection of osteopathic practice standards, and the long-term impact of such a significant change**.

For these reasons, we strongly recommend:

1. **Ensuring that licensees and stakeholders have a voice** in the study process.
2. **Guaranteeing DO representation and profession-specific protections** in any proposed changes.

3. **Conducting a comprehensive, impartial evaluation** before any decisions are made.
 - Share public minutes. Share documents for open comment period. Include stakeholders.

As one member succinctly put it: *“If we’re going to do this, we must do it right—with transparency, fairness, and a full understanding of the consequences.”*

We appreciate the opportunity to contribute to this discussion and look forward to continued collaboration. I welcome any questions or thoughts from the group.

Amanda Mahan, Executive Director
amahan@mainedo.org
207-623-1101

Member Feedback for BOL/BOLIM Workgroup



Maine Hospital Association

Sally Weiss

March 26, 2025

Hospital Operation Perspectives

Potential Benefits:

- Ease of only having to deal with two boards (Medicine-MD, DO, PA and Nursing--NP) for provider rules, requirements and reporting instead of three.
- More standardization in terms of requirements for licensure
- Alignment with most other states so less confusion when providers and medical staff office staff come from away.

Potential Barriers:

- All physicians would require 36 months of GME training for licensure, so a DO could not be hired with 12-35 months of training as is currently allowed.

Maine Residency Training Program Perspectives

Potential Benefits:

- Aligns all residents in terms of licensing which makes sense as now all GME is accredited by one agency, the ACGME.
- Saves time and money by only needing to get training licenses from one board
- Similarly, it assists program directors by only needing one set of rules for residents
- “I have found both organizations to be approachable and helpful with any questions I have about residents and their licenses, complaints or concerns. But, as with anything, a one-stop-shop is even better. Given accreditation is now all through one entity, it makes sense for licensing too.”

Potential Barriers:

- May limit ability of residents to moonlight until after 36 months of training. Currently DO's can moonlight after 12 months of training.

Board of Licensure in Medicine & Board of Osteopathic Licensure Procedures

These are general descriptions and do not include exceptions and individual details

Board Structure	Board Structure
• Chair • Secretary • 6 Physicians • 3 Public Members • 2 PAs • Meet Monthly (2nd Tuesday)	• Chair • Vice Chair • Secretary • 6 Physicians • 3 Public Members • 2 PAs • Meet Monthly (2nd Thursday)
BOLIM Rules	BOL Rules
• Chapter 1 – MD Licensure • Chapter 2 – Physician Assistants • Chapter 4 – Issuance of Citations • Chapter 5 – Collaborative Drug Therapy Management • Chapter 10 – Sexual Misconduct • Chapter 11 – Telehealth Standards • Chapter 12 – Office Based Treatment of Opioid Disorder • Chapter 21 – Use of Controlled Substances for Treatment of Pain	• Chapter 2 – Physician Assistants • Chapter 10 – Sexual Misconduct • Chapter 11 – Telehealth Standards • Chapter 12 – Office Based Treatment of Opioid Disorder • Chapter 14 – Continuing Medical Education • Chapter 16 – Prescribing and Treatment of Self and Family Members • Chapter 17 – Gifting • Chapter 21 – Use of Controlled Substances for Treatment of Pain
BOLIM Licensing Requirements for MDs	BOL Licensing Requirements for DOs
• Graduate from an accredited medical school or be ECFMG certified • 36 months of accredited post graduate training (PGT) • Pass USMLE 1, 2, 3 (time and attempt limits) • Active practice within past two years (for clinical licenses) • Pass the online, open book jurisprudence exam	• Graduate from an accredited osteopathic medical school • 12 months of accredited post graduate training (PGT) • Pass COMLEX 1, 2, 3 tests • Active practice within past two years

BOLIM Licensing Requirements for PAs	BOL Licensing Requirements for PAs
• Accredited PA school graduation • Pass the national exam - PANCE • Have current certification with NCCPA • Active practice within past two years (for clinical licenses) • 4,000 hrs of clinical work, or an Employer Agreement to work • Pass the online, open book jurisprudence exam	• Accredited PA school graduation • Pass the national exam - PANCE • Have current certification with NCCPA • Active practice within the past two years • 4,000 hrs of clinical work, or an Employer Agreement to work
BOLIM Licensing Process	BOL Licensing Process
• Applications are submitted online using the Uniform Application • FCVS verifies medical school, PGT and national examination (optional for PAs) • Maine's Application Addendum completed on our website • Original Affidavit mailed with original notary or <i>completed by electronic notarization</i> • Obtain the names and contact info for three references • Current Curriculum Vitae • Licensing Specialists gather all necessary information and create a packet • The application packet is reviewed by the Assistant Executive Director • If no issues - approved • If issues - referred to Secretary • Secretary can approve or refer to full Board	• Applications are submitted online using the Uniform Application • FCVS verifies medical school, PGT and national examination (optional for PAs) • Maine's Application Addendum completed on our website • Original Release Affidavit mailed to us with wet signature & original notary • Obtain two professional references for those who completed post-grad over a year prior. • Current Curriculum Vitae • Executive Secretary creates a packet • The Board reviews all applications
BOLIM IMLC	BOL IMLC
• Entered into system and issued	• Entered into system and issued

For Discussion Purposes Only

BOLIM Renewal Requirements	BOL Renewal Requirements
• Active practice within past two years (for clinical licenses) • 40 hours of AMA Category 1 CME every two years • 3 hours of opioid related CME every two years, regardless of prescribing practices • Pass the online, open book jurisprudence exam every 4 years	• Active practice within past two years • 100 hours of CME, with 40 of those AOA Category 1 CME every two years • If prescribing, 3 hours of opioid related CME required every two years
BOLIM Renewal Process	BOL Renewal Process
• Online renewal applications • If all requirements met and no yes answers – system renews • If not all requirements are met or there are yes answers – individual review by Licensing Specialist • Licensing Specialist gathers information, creates a packet and refers to Secretary for review • Secretary can approve or refer to full Board	• Online renewal applications • If all requirements met and no yes answers – system renews • If not all requirements are met or there are yes answers – individual review by Executive Secretary • Executive Secretary can approve after consulting with AAG, or refer to full Board
BOLIM Complaint Process	BOL Complaint Process
• Complaint received • Entered into ALMS • Complaint reviewed by staff to determine what information to request • Complainant acknowledged and licensee noticed of complaint (email only) • Licensee responds • Response shared with the complainant • Medical records reviewed and bookmarked by Medical Director • Packet assembled for Board review • Placed on the next available board agenda and a Board member is assigned as case reporter	• Complaint received • Entered into ALMS • Complaint reviewed by Executive Secretary to determine what information to request • Licensee notified by letter, USPS and email; response & medical records requested by subpoena within 30 days • Licensee responds, this is shared with complainant via consumer Assistant Specialist, who requests rebuttal if any within 10 days • After the 10 days has elapsed, the complaint documents are compiled and sent to the licensee/their attorney prior to meeting

• The Board file is shared with the licensee or attorney the Friday before the meeting • The complainant is notified the Friday before the meeting so they have an opportunity to attend • Complaint is summarized by case reporter at meeting, discussion held, decision made by motion, and voted upon	• Complainant & licensee are notified the week before the meeting in order to be able to attend if desired • Complaint is summarized by case reporter at meeting, discussion held, decision made by motion, and voted upon
BOLIM Assessment and Direction (2505 & 2506 reports)	BOL 2505 & 2506 Investigations
• Report received • Requests for additional information from the reporter sent • Necessary records obtained • Medical Director prepares packet • Placed on the next available Board agenda • Board determines whether to file or issue a complaint	• Report received • Request for additional information from the reporter sent • Necessary records obtained • Placed on the next Board agenda • Board determines whether to file or issue a complaint
BOLIM Malpractice Panel Process	BOL Malpractice Panel Process
• Panel includes: ○ Board Secretary ○ Medical Director ○ AAG ○ Executive Director • Claims reviewed to determine if records are needed and/or the matter needs to go to the full Board before adjudication include: ○ Wrongful death ○ Wrong site surgery or ○ Sexual misconduct • Settlements and judgements reviewed to determine if records are needed and/or the matter needs to go to the full Board include: ○ Incident occurred in the past 10 years	• No specific panel for this – Either Executive Secretary or full Board handles this • Claims reviewed initially by AAG to see if additional info needed • Claims reviewed by Executive Secretary to determine if the matter needs to go to the Board • Judgements/Settlements reviewed by Board to determine if more information is needed, or if action is needed

○ Wrongful death ○ Wrong site surgery ○ Sexual misconduct ○ \$500,000 or more ○ 3 or more settlements in the past 10 years ○ \$300,000 or more settlement and 1 pending claim	
BOLIM Agenda Workgroup	BOL
• The workgroup includes ○ Board Chair ○ Public Member ○ Medical Director ○ AAG • Staff refers cases to the agenda workgroup if, in their opinion, the case is likely to be dismissed by the Board. • If all workgroup members agree with dismissal a motion is written and given to the full Board with the file • If the workgroup is not unanimous, the complaint goes to the full Board according to the regular process	• All complaints are brought to the full Board regardless of the possibility of dismissal.

Board of Licensure in Medicine - Board of Osteopathic Licensure
Workgroup
ZOOM meeting
April 30, 2025
5:31 p.m. – 6:37 p.m.

Board Members Present

Public Member Peter Michaud, JD, RN (BOL)
Public Member Dennis Smith, Esq. (BOL)
Christine Munroe, DO (BOL)
Lisa Ryan, DO (BOL)
John Brewer, DO (BOL)
Public Member Lynne Weinstein (BOLIM)
Renee Fay-LeBlanc, MD (BOLIM)

Board Staff Present

Executive Director Timothy Terranova (BOLIM)
Assistant Executive Director Valerie Hunt (BOLIM)
Paul Smith, MD, Medical Director (BOLIM)
Kelly McLaughlin, Complaint Coordinator (BOLIM)

Legal Counsel Present

AAG Lisa Wilson (BOL)
AAG Jennifer Willis (BOLIM)

A roll call of board members present was conducted.

Discussion

As requested at the last workgroup meeting, the financials, including current (as of 2/28/25) financial statements of each board and a draft conceptual budget if the boards were to be combined were provided and reviewed. Ms. Hunt asked those present if there were any questions regarding those documents, and there were none.

The discussion moved to the next item on the agenda, the draft Question and Answer sheet that workgroup members had requested be prepared by staff for further discussion (prior workgroup discussion also referred to this document as an FAQ). Questions were raised regarding the proposed composition of the board as included in that initial Q&A draft, with questions of reducing the total number of board members if the boards merged. It was suggested that board composition would be part of the workgroup's ongoing discussion of whether and how a merger might occur.

Workgroup members also discussed the request by non-Board members to join the workgroup. Board counsel indicated that this was not legally advisable without clear legal authority.

Workgroup members discussed the function of the workgroup and what is needed to move forward. The discussion included that the January, February and March meetings provided background information to questions that would help determine if a merger is feasible and if the boards should

move forward with that recommendation. The Workgroup members then discussed that the next step ought to be considering whether or not a merger should happen and that getting public comment would be a critical part of that discussion.

Mr. Terranova requested that the workgroup make a timeline for a decision. He indicated that, if the workgroup decided a merger was not feasible, the workgroup's mission would be complete, and a report of that determination would be prepared for the Legislature. The workgroup discussed the potential approaches if the Boards ultimately decided to recommend a merger. There was general agreement among the workgroup members that any recommendation to the Legislature in favor of or recommending merger should be accompanied by recommendations for how a merged board should look and function, and that this should include proposed draft statutory language to replace existing separate statutes for the Boards.

Mr. Terranova reported that the Maine Osteopathic Association (MOA) was inviting members of the workgroup to attend and participate in the MOA Annual Convention in June. Mr. Terranova indicated that, in his opinion, it would be more appropriate for BOL members and staff to attend. The workgroup agreed that BOL members would attend.

The workgroup determined that:

- The May workgroup meeting should be used to invite and hear full public comment in favor or against merger.
- Some members of the Osteopathic Board plan to attend the MOA Annual Convention in June and report back to the workgroup at the June workgroup meeting.
- The individual Boards should be provided with all workgroup materials, including all public comments, for consideration at their July meetings and the workgroup would request that each Board vote either to recommend moving forward with the process of discussing merger feasibility or determining that a merger is not feasible.

Mr. Terranova reminded the workgroup that if they voted to move forward and then determined the details could not be agreed upon, the workgroup could change its recommendation prior to submission to the legislature.

Next Steps

The workgroup agreed to dedicate the May 28th meeting to public comment. Workgroup members asked that a court reporter be present for the meeting to ensure a complete transcript of comments be created and made available.

The workgroup would like the draft Q&A / FAQ document sent to workgroup members for editing, with the goal of posting it to the website prior to the May meeting. Workgroup proposed edits will be sent to Rachel MacArthur and Tim Terranova, who will compile and circulate those.

The next workgroup meeting will be held on May 28th beginning at 5:30 p.m.

Public Comment

Charlie Soltan (MOA lobbyist) indicated that he disagrees with the AAG's interpretation of the boards' abilities to include non-Board members as voting members in the workgroup. Mr. Soltan indicated he is not opposed to a merger of the boards, but that he and the organization need a larger voice and a seat at the table.

Jodie Hermann, DO (MOA President) indicated that she and the organization is not necessarily opposed to a merger but want to ensure that any merger is done in a thoughtful manner with input from stakeholders. Dr. Hermann indicated she was glad that members of the Osteopathic Board would be present at the MOA meeting in June.

Adjourn 6:37 pm

Board of Licensure in Medicine
Board of Osteopathic Licensure

Based on FY25 Budgeted Amounts

	<u>Medicine</u>	<u>Osteo</u>	<u>Inc/(Dec)</u>	<u>One-time</u>	<u>Merged</u>	<u>Notes</u>
Headcount						
Staff (# of Positions)	12	1	0	0	13	??
Board Members	11	11	-4	0	18	* Reducing 2 from each board
Personal Services						
Labor	\$ 1,395,611.00	\$ 110,105.00	\$ -	\$ -	\$ 1,505,716.00	* No planned changes to staffing, but may eliminate vacant positions. Higher costs potentially for Board members b/c of MED's procedure
PS Subtotal	\$ 1,395,611.00	\$ 110,105.00	\$ -	\$ -	\$ 1,505,716.00	
All Other						
Contracts (Line 40)	\$ 299,681.00	\$ 18,237.00	\$ -	\$ 10,000.00	\$ 327,918.00	* (MED) Maine Medical Assoc, Hearing Officer. One-time expense to re-do instructional videos
AG's Office and Service Center (Line 41)	\$ 310,545.00	\$ 145,725.00	\$ -	\$ -	\$ 456,270.00	* (MED) 1 AAG' and 1 Investigator; (OSTEO) 1 AAG and 1 Investigator (partial). Same costs.
Travel (Lines 42, 43)	\$ 27,005.00	\$ -	\$ (2,700.00)	\$ -	\$ 24,305.00	*Reduced In-state travel costs
Office Space (Lines 45,46,47, and 56)	\$ 112,072.00	\$ 17,668.00	\$ -	\$ 15,000.00	\$ 144,740.00	* No change in leased space. PLACEHOLDER for one-time costs including Office reconfig.
General Operations (Line 49)	\$ 119,404.00	\$ 21,395.00	\$ -	\$ 10,000.00	\$ 150,799.00	* (MED) Contracts for Evaluators, Expert Witnesses, CC Fees, etc.; PLACEHOLDER for Rulemaking, new letterhead, business cards/envelopes, etc. Anything that has to be renamed?
Office of Information Tech. (Line 53)	\$ 92,666.00	\$ 8,021.00	\$ 23,401.00	\$ -	\$ 124,088.00	* 7 more laptops for Board (total of 18 laptops)
3rd party Tech. (Line 55)	\$ 19,454.00	\$ 3,000.00	\$ -	\$ 20,000.00	\$ 42,454.00	*PLACEHOLDER for ALMS costs; website redesign
Other expenses	\$ 31,839.00	\$ 5,421.00	\$ -	\$ -	\$ 37,260.00	* STACAP (overhead), etc.
AO Subtotal	\$ 1,012,666.00	\$ 219,467.00	\$ 20,701.00	\$ 55,000.00	\$ 1,307,834.00	
Revenue						
New Licenses	\$ 555,000.00	\$ 66,350.00			\$ 621,350.00	
Renewals	\$ 1,400,000.00	\$ 291,650.00			\$ 1,691,650.00	
Other	\$ 440,333.00	\$ 7,357.00			\$ 447,690.00	
Revenue Subtotal	\$ 2,395,333.00	\$ 365,357.00	\$ -	\$ -	\$ 2,760,690.00	<i>Fee structure changes to be discussed...</i>
Transfers						
Transfers Subtotal	\$ (257,032.00)	\$ (25,742.00)	\$ -	\$ -	\$ (282,774.00)	
Net	\$ (269,976.00)	\$ 10,043.00			\$ (259,933.00)	

(*MED Net actuals are positive in FY25)

SIDE NOTES aka Things to discuss, but not necessarily presented

Additional costs/considerations

* Savings will come from being able to scale support (better, faster response) without having to increase staff

* (OSTEO) increasing initial license fees. Same fees for MD's and DO's?

Board of Osteopathic Licensure

Summary - YTD 2/28/2025

Beginning Cash Balance FY25	\$909,717.78
Total Revenue YTD	283,375.50
Total Expenses/Encs./Transfers YTD	148,118.47
Available Cash Balance	<u>\$ 1,044,974.81</u>

	FY25 Budget	FY25 Actual	FY25 Remaining	FY25% Act/Bdgt	1st Qtr. Budget	1st Qtr. Actual	1st Qtr. % Act/Bdgt	2nd Qtr. Budget	2nd Qtr. Actual	2nd Qtr. % Act/Bdgt	3rd Qtr. Budget	3rd Qtr. Actual	3rd Qtr. % Act/Bdgt	4th Qtr. Budget	4th Qtr. Actual	4th Qtr. % Act/Bdgt
TOTAL REVENUE	370,674.00	283,375.50	87,298.50	76%	84,075.00	114,897.00	137%	95,348.00	121,473.00	127%	123,366.00	47,005.50	38%	67,885.00	-	0%
PERSONAL SERVICES	110,105.00	65,745.20	44,359.80	60%	35,240.00	24,840.00	70%	32,250.00	26,665.23	83%	29,261.00	14,239.97	49%	13,354.00	-	0%
ALL OTHER	219,467.00	66,635.09	152,831.91	30%	83,227.00	22,494.83	27%	48,759.00	30,866.03	63%	43,739.00	13,274.23	30%	43,742.00	-	0%
CAPITAL	-	-	-	0%	-	-	0%	-	-	0%	-	-	0%	-	-	0%
TRANSFERS OUT	25,742.00	15,738.18	10,003.82	61%	5,106.00	7,277.65	143%	5,106.00	3,588.20	70%	5,106.00	4,872.33	95%	10,424.00	-	0%
TOTAL	355,314.00	148,118.47	207,195.53	42%	123,573.00	54,612.48	44%	86,115.00	61,119.46	71%	78,106.00	32,386.53	41%	67,520.00	-	0%
NET	15,360.00	135,257.03	(119,897.03)	881%	(39,498.00)	60,284.52	-153%	9,233.00	60,353.54	654%	45,260.00	14,618.97	32%	365.00	-	0%
ALL OTHER EXPENSES																
4000 PROF. SERVICES, NOT BY STATE	18,237.00	10,645.52	7,591.48	58%	18,237.00	710.02	4%	-	5,710.00	0%	-	4,225.50	0%	-	-	0%
4100 PROF. SERVICES, BY STATE	145,725.00	11,515.00	134,210.00	8%	36,431.00	6,909.00	19%	36,431.00	4,606.00	13%	36,431.00	-	0%	36,432.00	-	0%
4200 TRAVEL EXPENSES, IN STATE	-	-	-	0%	-	-	0%	-	-	0%	-	-	0%	-	-	0%
4300 TRAVEL EXPENSES, OUT OF STATE	-	-	-	0%	-	-	0%	-	-	0%	-	-	0%	-	-	0%
4500 UTILITY SERVICES	-	-	-	0%	-	-	0%	-	-	0%	-	-	0%	-	-	0%
4600 RENTS	15,616.00	11,748.23	3,867.77	75%	5,532.00	3,940.73	71%	5,532.00	3,903.75	71%	2,276.00	3,903.75	172%	2,276.00	-	0%
4700 REPAIRS	-	-	-	0%	-	-	0%	-	-	0%	-	-	0%	-	-	0%
4800 INSURANCE	400.00	1,892.74	(1,492.74)	473%	400.00	1,817.74	454%	-	75.00	0%	-	-	0%	-	-	0%
4900 GENERAL OPERATIONS	21,395.00	20,201.11	1,193.89	94%	16,599.00	6,186.91	37%	1,599.00	11,534.93	721%	1,598.00	2,479.27	155%	1,599.00	-	0%
5000 EMPLOYEE TRAINING	-	-	-	0%	-	-	0%	-	-	0%	-	-	0%	-	-	0%
5100 COMMODITIES - FOOD	300.00	16.74	283.26	6%	75.00	-	0%	75.00	-	0%	75.00	16.74	22%	75.00	-	0%
5300 TECHNOLOGY	8,021.00	5,471.76	2,549.24	68%	2,005.00	1,082.46	54%	2,005.00	2,969.51	148%	2,005.00	1,419.79	71%	2,006.00	-	0%
5500 TECHNOLOGY, NON-STATE	3,000.00	1,277.30	1,722.70	43%	750.00	325.63	43%	750.00	732.31	98%	750.00	219.36	29%	750.00	-	0%
5600 OFFICE & OTHER SUPPLIES	2,052.00	834.65	1,217.35	41%	513.00	403.98	79%	513.00	64.76	13%	513.00	365.91	71%	513.00	-	0%
8200 NSF CHARGES	-	-	-	0%	-	-	0%	-	-	0%	-	-	0%	-	-	0%
8511 TRANS TO GEN FUND STACAP	4,721.00	3,032.04	1,688.96	64%	2,685.00	1,118.36	42%	1,854.00	1,269.77	68%	91.00	643.91	708%	91.00	-	0%
TOTAL ALL OTHER	219,467.00	66,635.09	152,831.91	30%	83,227.00	22,494.83	27%	48,759.00	30,866.03	63%	43,739.00	13,274.23	30%	43,742.00	0.00	0%

Board of Medicine

Summary - YTD 2/28/2025

Beginning Cash Balance FY25	\$ 5,165,377.77
Total Revenue YTD	\$ 1,823,758.00
Total Expenses/Encs./Transfers YTD	\$ 1,526,670.49
Available Cash Balance	<u>\$ 5,462,465.28</u>

	FY25 Budget	FY25 Actual	FY25 Remaining	FY25 % Act/Bdgt	1st Qtr. Budget	1st Qtr. Actual	1st Qtr. % Act/Bdgt	2nd Qtr. Budget	2nd Qtr. Actual	2nd Qtr. % Act/Bdgt	3rd Qtr. Budget	3rd Qtr. Actual	3rd Qtr. % Act/Bdgt	4th Qtr. Budget	4th Qtr. Actual	4th Qtr. % Act/Bdgt
TOTAL REVENUE	2,395,333.00	1,823,758.00	571,575.00	76%	563,933.00	647,579.00	115%	564,233.00	782,854.00	139%	568,633.00	393,325.00	69%	698,534.00	-	0%
PERSONAL SERVICES	1,395,611.00	821,274.17	574,336.83	59%	451,303.00	290,696.83	64%	421,574.00	339,891.57	81%	377,878.00	190,685.77	50%	144,856.00	-	0%
ALL OTHER	1,012,666.00	585,681.27	426,984.73	58%	498,133.00	428,669.27	86%	171,500.00	98,378.76	57%	170,513.00	58,633.24	34%	172,520.00	-	0%
CAPITAL	-	-	-	0%	-	-	0%	-	-	0%	-	-	0%	-	-	0%
TRANSFER OUT	257,032.00	119,715.05	137,316.95	47%	39,000.00	53,063.55	136%	39,000.00	29,166.96	75%	39,000.00	37,484.54	96%	140,032.00	-	0%
TOTAL	2,665,309.00	1,526,670.49	1,138,638.51	57%	988,436.00	772,429.65	78%	632,074.00	467,437.29	74%	587,391.00	286,803.55	49%	457,408.00	-	0%
NET	(269,976.00)	297,087.51	(567,063.51)	-110%	(424,503.00)	(124,850.65)	29%	(67,841.00)	315,416.71	-465%	(18,758.00)	106,521.45	-568%	241,126.00	-	0%
ALL OTHER EXPENSES																
4000 PROF. SERVICES, NOT BY STATE	299,681.00	269,377.51	30,303.49	90%	299,681.00	264,108.98	88%	-	5,254.06	0%	-	14.47	0%	-	-	0%
4100 PROF. SERVICES, BY STATE	310,545.00	25,237.00	285,308.00	8%	77,637.00	8,404.00	11%	77,637.00	16,808.00	22%	77,636.00	25.00	0%	77,635.00	-	0%
4200 TRAVEL EXPENSES, IN STATE	6,807.00	524.94	6,282.06	8%	1,327.00	239.00	18%	1,327.00	-	0%	1,327.00	285.94	22%	2,826.00	-	0%
4300 TRAVEL EXPENSES, OUT OF STATE	20,198.00	6,865.07	13,332.93	34%	6,625.00	3,856.55	58%	4,323.00	3,008.52	70%	3,625.00	-	0%	5,625.00	-	0%
4500 UTILITY SERVICES	5,331.00	-	5,331.00	0%	1,333.00	-	0%	1,333.00	-	0%	1,333.00	-	0%	1,332.00	-	0%
4600 RENTS	93,211.00	68,485.29	24,725.71	73%	23,303.00	22,828.43	98%	23,303.00	22,828.43	98%	23,303.00	22,828.43	98%	23,302.00	-	0%
4700 REPAIRS	742.00	-	742.00	0%	186.00	-	0%	186.00	-	0%	186.00	-	0%	184.00	-	0%
4800 INSURANCE	2,800.00	5,062.00	(2,262.00)	181%	2,800.00	4,900.00	175%	-	162.00	0%	-	-	0%	-	-	0%
4900 GENERAL OPERATIONS	119,404.00	121,058.10	(1,654.10)	101%	42,999.00	94,465.15	220%	25,469.00	13,475.45	53%	25,468.00	13,117.50	52%	25,468.00	-	0%
5000 EMPLOYEE TRAINING	11,495.00	598.78	10,896.22	5%	2,874.00	42.25	1%	2,874.00	556.53	19%	2,874.00	-	0%	2,873.00	-	0%
5100 COMMODITIES - FOOD	1,035.00	128.42	906.58	12%	372.00	46.17	12%	221.00	25.47	12%	221.00	56.78	26%	221.00	-	0%
5300 TECHNOLOGY	92,666.00	55,249.80	37,416.20	60%	23,168.00	18,222.09	79%	23,166.00	22,004.46	95%	23,166.00	15,023.25	65%	23,166.00	-	0%
5500 TECHNOLOGY, NON-STATE	19,454.00	13,550.88	5,903.12	70%	4,864.00	4,905.58	101%	4,864.00	5,274.94	108%	4,864.00	3,370.36	69%	4,862.00	-	0%
5600 OFFICE & OTHER SUPPLIES	12,788.00	5,896.63	6,891.37	46%	4,697.00	1,633.71	35%	2,697.00	3,679.59	136%	2,697.00	583.33	22%	2,697.00	-	0%
8511 TRANS TO GEN FUND STACAP	16,509.00	13,646.85	2,862.15	83%	6,267.00	5,017.36	80%	4,100.00	5,301.31	129%	3,813.00	3,328.18	87%	2,329.00	-	0%

Board of Licensure in Medicine & Board of Osteopathic Licensure

Question & Answer

Are MD's and DO's currently licensed by separate boards?
➤ Yes, The Board of Osteopathic Licensure (BOL) licenses osteopathic physicians and physician assistants. The Board of Licensure in Medicine (BOLIM) licenses allopathic physicians and physician assistants. Maine is one of twelve (12) states that has separate boards.
Why are there two licensing boards?
➤ BOLIM began licensing allopathic physicians in 1895. When osteopathic physicians requested licensure from the state, they were given a separate board, BOL, in recognition of their focus on osteopathic medicine, including osteopathic manipulation.
What are other states doing?
➤ Boards have changed over time with a high of 30 states having separate boards in 1939. Today only 12 states have separate medical and osteopathic boards. Three states have consolidated medical and osteopathic boards since 2021. (Data provided by the Federation of State Medical Boards)
What has changed?
➤ MDs, DOs and PAs work side by side in a collaborative manner every day. The post graduate training for MDs and DOs are accredited by the same organization, and DOs and MDs can be found in every specialty. With the exception that DOs have additional training in osteopathic ideals, the education, training and examination requirements are similar.
What are the missions of the boards?
➤ The mission of both boards is the same: Protect the health, safety and welfare of Maine citizens.
Do the boards currently collaborate?

- Yes, the boards currently have 5 joint rules and share one staff person.

Why are the boards considering merging?

- There are several reasons for a proposed merger of the two boards. BOL has one (1) full-time employee that is responsible for all aspects of board functions, including administrative, legislative, licensing and investigative. BOLIM has ten (10) full-time employees. BOLIM currently reviews approximately 30 complaints and investigations each month. BOL sees a quarter to a third of that number each month. Merging would allow the work to be distributed among more members and may also allow for more efficient processing of licensing, complaints, investigations and hearings. There is a growing recognition in the profession that health care is delivered in a collaborative team setting. Merging would reflect the current realities of practice by placing three members of the collaborative health care team under one board. Although not yet determined, the boards are also looking to see what financial impact a merger would have.

Can MDs judge complaints against DOs and vice versa?

- Currently, DOs, PAs and public members evaluate and adjudicate complaints against DOs. Likewise, MDs, PAs and public members evaluate and adjudicate complaints against MDs. When there is a question of practice that is outside of the specialty of board members, the case is referred to an outside expert in the field for review, which board members then use to make a determination on the outcome of the case.

What would representation look like on a merged board?

- Although the boards have not settled on firm numbers, they are still studying the feasibility, they have agreed in principle that equal representation for DOs and MDs is required and that consistent proportional representation for PAs and public members is also required.

How can I find more information?

- More information and updates can be found on the boards' websites, www.maine.gov/osteo and www.maine.gov/md.

How can I provide input?

- The boards have created a workgroup that meets once a month. There will be time for public comment at those meetings. In addition, you can email questions and comments to board staff at tim.e.terrano@maine.gov and rachel.macarthur@maine.gov. Please copy both on any correspondence.

Board of Licensure in Medicine - Board of Osteopathic Licensure
Workgroup
ZOOM meeting
May 28, 2025
5:32 p.m. – 6:32 p.m.

Board Members Present

Maroulla Gleaton, MD (BOLIM)
Renee Fay-LeBlanc, MD (BOLIM)
Lisa Ryan, DO (BOL)
John Brewer, DO (BOL)
Public Member Peter Michaud, JD, RN (BOL)
Paul Vinsel, DO (BOL)

Board Staff Present

Assistant Executive Director Valerie Hunt (BOLIM)
Administrative Assistant Maureen Lathrop (BOLIM)
Licensing Specialist Savannah Okoronkwo (BOLIM)
Executive Secretary Rachel MacArthur (BOL)

Legal Counsel Present

AAG Lisa Wilson (BOL)
AAG Jennifer Willis (BOLIM)

A roll call of board members present was conducted.

Discussion

Amanda Mahan from the Maine Osteopathic Association, Kathryn Brandt, DO, Jodie Herman, DO and Donald McFadden, DO offered comments.

Workgroup members discussed that receiving feedback with specific concerns and issues faced by licensees would be helpful as issues may be solved by statutory structure. For those opposed to merging the two Boards specific reasons and suggestions for mitigating harm would be helpful.

There was discussion regarding the importance of having a Board member trained in Osteopathic Manipulation. There is currently no statutory requirement that a member of the Osteopathic Board be trained in Osteopathic Manipulation. Other Boards do have requirements for specific practices, so that could be included in statute.

Workgroup members discussed concerns that a merged Board would need sufficient representation of specialties to review cases fairly. Members noted that both Boards utilize opportunities to outsource expert reviews when they feel a case is outside of their scope.

Ms. MacArthur offered her comments that the workload is going to become unmanageable at some point, and she needs additional resources.
The next meeting is June 25th at 5:30 pm.

Adjourn 6:32 pm

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STATE OF MAINE
BOARD OF LICENSURE IN MEDICINE

* * * * *

IN RE: WORKSHOP MEETING

* * * * *

This workshop meeting was held virtually via Zoom
videoconference, pursuant to notice of meeting on May
28, 2025, beginning at 5:31 p.m.

Court Reporter:	Debra J. Fusco
	Alley & Morrisette Reporting
	207-495-3900

1 (This workshop meeting was held virtually via Zoom
2 videoconference, pursuant to notice of meeting on May
3 28, 2025, beginning at 5:31 p.m.)

4 * * * * *

5 MS. MACARTHUR: Good evening. My name is
6 Rachel MacArthur, and I am the Executive Secretary of
7 the Maine Board of Osteopathic Licensure. With me is
8 Valerie Hunt, Assistant Executive Director of the Maine
9 Board of Licensure in Medicine.

10 In accordance with the BOLIM Board Member
11 Remote Participation Policy adopted by BOLIM on
12 November 14, 2023, the Board Chair approved all Board
13 Members to participate remotely for today's meeting of
14 the Board pursuant to Section 2(F) of that policy.

15 Members of the public may attend the
16 workgroup meeting in person at the Board's offices in
17 Augusta. In addition, the meeting is being made
18 virtually available to the public not attending the
19 meeting in person through the platform Zoom. A link for
20 the public to access the meeting virtually was posted on
21 BOLIM's website. Savannah Okoronkwo is the electronic
22 operator and host clerk for the virtual portion of the
23 meeting, and will perform the duties of the meeting
24 organizer such as muting, un-muting speakers and
25 controlling what will be displayed visually.

1 It is the Board's sincere hope that all of
2 those interested in the subject matter of today's
3 meeting have received notice of the meeting and how to
4 observe either in person or electronic.

5 I would like to go over some ground rules
6 for this meeting.

7 One, Board Staff have established the Zoom
8 meeting to allow public observation only. Members of
9 the public are asked to mute their lines and turn off
10 video cameras. The host clerk will force mute lines and
11 turn off video cameras. Three, the Board meeting will
12 be conducted with Board Members displayed visually and
13 un-muted. Four, the use of the chat function will not
14 be used. To the extent possible, that function has been
15 disabled for this meeting. Five, for Board Members and
16 Board Staff who are participating in the meeting, here
17 are some helpful hints. All phones and cell phones
18 should be on mute at this time. Thank you. If anybody
19 requires a bathroom break, please speak up and request a
20 break in the meeting. Members of the public who are
21 attending the meeting in person are cautioned not to
22 speak during the meeting as it may be picked up by the
23 microphone and unnecessarily disrupt the meeting and/or
24 the ability of the public to access the meeting
25 virtually to hear the Board Members. Members of the

1 public who are attending the meeting in person are
2 cautioned not to approach the Board Members or to engage
3 them in discussion. Board Members are here today to
4 conduct the business of the Board, and the Board Staff
5 is here today to support the Board in conducting its
6 business. Members of the public who are attending in
7 person and are having difficulty hearing the discussion
8 should log onto the Zoom meeting using their personal
9 devices and listen using headphones. Access to the
10 Board Staff offices is restricted to Board Staff and
11 members.

12 The meeting today will follow, as best as
13 possible, the agenda which will consist of
14 introductions, public comment, next steps and
15 adjournment.

16 I will now take a roll call of Board Members
17 and identify staff presence. When I call your name,
18 please indicate your presence.

19 For BOLIM Board Members:

20 Maroulla Gleaton.

21 DR. GLEATON: (Indicating.)

22 MS. MACARTHUR: Christopher Ross.

23 MR. ROSS: (Indicating.)

24 MS. MACARTHUR: Holly Fanjoy.

25 DR. FANJOY: (Indicating.)

1 MS. MACARTHUR: Renee Fay-LeBlanc.

2 DR. FAY-LEBLANC: Here.

3 MS. MACARTHUR: I apologize if I
4 mispronounce anybody's name.

5 David Flaherty.

6 MR. FLAHERTY: (Indicating.)

7 MS. MACARTHUR: Gregory Jamison.

8 MR. JAMISON: (Indicating.)

9 MS. MACARTHUR: Noah Nesin.

10 DR. NESIN: (Indicating.)

11 MS. MACARTHUR: Anthony Ng.

12 DR. NG: (Indicating.)

13 MS. MACARTHUR: Jonathan Sahrbeck.

14 MR. SAHRBECK: (Indicating.)

15 MS. MACARTHUR: Brad Waddell.

16 DR. WADDELL: (Indicating.)

17 MS. MACARTHUR: Lynne Weinstein.

18 MS. WEINSTEIN: (Indicating.)

19 MS. MACARTHUR: All right. Next we have the
20 BOL, Board of Osteopathic Licensure, Board Members.

21 Christine Munroe.

22 DR. MUNROE: (Indicating.)

23 MS. MACARTHUR: Lisa Ryan.

24 DR. RYAN: Here.

25 MS. MACARTHUR: John Brewer.

1 DR. BREWER: Here.

2 MS. MACARTHUR: Melissa Michaud.

3 MS. MICHAUD: (Indicating.)

4 MS. MACARTHUR: Brian Gillis.

5 DR. GILLIS: (Indicating.)

6 MS. MACARTHUR: Peter Michaud.

7 MR. MICHAUD: Here.

8 MS. MACARTHUR: Gust Stringos.

9 DR. STRINGOS: (Indicating.)

10 MS. MACARTHUR: Paul Vinsel.

11 DR. VINSEL: Here.

12 MS. MACARTHUR: Dennis Smith.

13 MR. SMITH: (Indicating.)

14 MS. MACARTHUR: Mary-Anne Ponti.

15 MS. PONTI: (Indicating.)

16 MS. MACARTHUR: And that's everybody on the

17 Board.

18 We have staff members: Myself, Rachel

19 MacArthur, Executive Secretary. We have Valerie Hunt,

20 the Assistant Executive Director. Kelly McLaughlin is

21 not here. Faith McLaughlin I believe is not here.

22 Nathan Fitts is here. Maureen Lathrop is here.

23 Savannah Okoronkwo is here. And Jennifer Willis, and

24 Lisa Wilson.

25 MS. WILSON: Here.

1 MS. MACARTHUR: Oh, there you are.

2 All right.

3 DR. GLEATON: This is Maroulla Gleaton. I'm
4 sorry, I found my mute button. I'm here.

5 MS. MACARTHUR: We saw you wave.

6 DR. GLEATON: Thank you. I'll re-mute.

7 MS. MACARTHUR: As indicated, the purpose of
8 this meeting is to gather public input. The workgroup
9 hopes all individuals providing comments this evening
10 have reviewed the previous meeting notes and the FAQ
11 posted on the Boards' websites. Those individuals on
12 Zoom wishing to provide comments should raise their
13 electronic hand. I will call on each person as they
14 appear on my screen. Once called, please start your
15 video and un-mute your line. Those individuals
16 attending the meeting at the Board office can indicate
17 to staff that they would like to provide comments.

18 Please remember that this is an opportunity
19 to provide information, but it is not intended to become
20 a back and forth discussion. Workgroup members will
21 listen to the comments, and all comments will be
22 transcribed for members who are not present. The
23 transcription will also be posted on the Boards'
24 websites. Depending on the number of people wishing to
25 provide comments, the workgroup may decide to place a

1 time limit.

2 How many members of the public are currently
3 on? So there's 21 total people on, including Board
4 Members, okay. How much time would the workgroup like
5 to allocate for each speaker?

6 MR. MICHAUD: Do we know how many people
7 wish to speak?

8 MS. MACARTHUR: I haven't been given any --
9 I have one e-mail from a PA, and that's it.

10 MS. WILLIS: Maybe we could start with the
11 raised hands, and get the participant list of folks who
12 want to participate, and then get that information to
13 Board Members.

14 MS. MACARTHUR: Yeah. If you're interested
15 in speaking, giving a comment, if you could raise your
16 hand, that would be great.

17 MS. WILLIS: And, Deb, my apologies. This
18 is Jen Willis. I am off camera on the big camera. I am
19 the Assistant Attorney General for the Board of
20 Licensure in Medicine, and I was the one who just made
21 that suggestion. You had asked us to identify
22 ourselves, so I'm trying to model that behavior.

23 MADAM REPORTER: Thank you.

24 MS. MACARTHUR: So I'm not seeing any hands
25 raised.

1 MS. HUNT: Hi, this is Valerie Hunt,
2 Assistant Executive Director. If you are looking for
3 the option to raise your hand, it is under "react." If
4 you look at the bottom, there is a heart symbol. And if
5 you click on that, there is the option to raise hand for
6 anyone that may not know where that is located.

7 MR. MICHAUD: This is Peter Michaud again.
8 If there are very few people who want to
9 speak, I'm in favor of giving them pretty much as much
10 time as they want. If we have a large number of people,
11 then we would have to restrict the time, but I think we
12 should err on the side of getting as much input as
13 possible.

14 MS. MACARTHUR: Agreed.

15 DR. GLEATON: I agree with that. This is
16 Maroulla Gleaton. I agree with that comment.

17 MS. MACARTHUR: In addition, to allow
18 everyone a chance to provide information, individuals
19 will not be allowed a second chance to present this
20 evening, unless the workgroup agrees to allow it.
21 However, you can provide content at any time by
22 e-mailing myself, Rachel MacArthur, or Tim Terranova.
23 Our e-mail addresses can be found on our websites.

24 Are there any questions from workgroup
25 members before we begin public comment?

1 (No response.)

2 MS. MACARTHUR: All right. Well, since
3 there aren't any hands raised, I guess I will read this
4 e-mail that was sent to myself and Mr. Terranova on
5 May 27th.

6 "I am writing in strong support of combining
7 the Board of Licensure in Medicine with the Board of
8 Osteopathic Licensure. As you may recall, I contacted
9 the Boards on more than one occasion about the work
10 challenges I have had since the decision was made to
11 stop allowing PAs to change supervising boards. I have
12 been a PA since 2010, first registered with BOLIM, and
13 later with the Osteopathic Board in 2016 when I changed
14 roles and had a supervising physician who was a DO.
15 Consequently, every time a pharmacy or a member of the
16 general public searches for my license online, they are
17 directed to the BOLIM site which lists my license as
18 withdrawn. Readers are not given a reason for the
19 withdrawal or a redirection to the Osteo Board site
20 where my license is located. This has led to
21 significant delays in patient care, and has impacted my
22 credibility with my patients. My office colleagues are
23 frustrated with the additional time they need to spend
24 calling pharmacies and directing them to the correct
25 site, and we have had to reassure patients of my

1 credentials on multiple occasions. Combining boards
2 would resolve PA licensure confusion, allowing
3 pharmacists and the general public to access one site
4 for licensed confirmation for PAs and removing the
5 workforce challenges and delays in patient care that the
6 existing two boards originally created. Thank you."

7 Any commentary on that?

8 MR. MICHAUD: Do we know how many PAs are
9 licensed by both boards together?

10 MS. MACARTHUR: They're actually not
11 supposed to be.

12 MR. MICHAUD: No, I don't mean dual
13 licensure. I mean what is the total number of PAs
14 licensed in Maine?

15 DR. GLEATON: We should have that number.
16 BOLIM has that number on their site, I'm sure.

17 MS. HUNT: Yeah, I believe it's a little
18 under 2,000.

19 MS. MACARTHUR: We have very few. We have
20 -- I mean maybe a hundred. Very few.

21 MR. MICHAUD: So 2,000, that's an awful lot
22 of people who would be in the same position as the
23 person who wrote.

24 DR. GLEATON: Well, they could be.

25 MS. MACARTHUR: If they switched sides, I

1 guess.

2 MR. MICHAUD: If they had switched, yeah.

3 MS. MACARTHUR: We were just, actually
4 today, working on somebody who ended up applying for a
5 PA license on both boards, and there was kind of a
6 paperwork thing that we had to fix.

7 DR. BREWER: Could I just ask, are we aware
8 of any other PAs that have experienced the same thing,
9 having difficulty getting recognized as they switched?

10 MS. MACARTHUR: That specific issue, I
11 haven't had anybody tell me about that type of issue
12 previously. We do have, often, people who will e-mail
13 me who need to e-mail them, or vice versa, because
14 they're on the opposite board of the one that they've
15 contacted.

16 MS. HUNT: Peter, I have an exact number for
17 you. So BOLIM currently licenses 1,344 physician
18 assistants.

19 MR. MICHAUD: Thank you.

20 MS. HUNT: You're welcome.

21 MS. MACARTHUR: Amanda, would you like me to
22 read this?

23 MS. MAHAN: Hi everybody.

24 I'm happy to speak on behalf of the MOA. We
25 have a couple board members who are on the call, but

1 they are in the car and are having a little difficulty
2 coming off of mute.

3 You all have heard from us. I think our
4 main concerns in this process are really to honor that
5 we have a lot of members who are concerned about, you
6 know, the loss of identity of losing a separate board
7 and just concerned, you know, with maintaining a lot of
8 the philosophy pieces and a lot of the culture that we
9 feel is working really well with the Osteopathic Board.
10 And, you know, the differences in practice are still
11 real in some cases. So we think it's important for
12 those to be reflected no matter how we move forward.
13 Obviously, we recognize that there are some operational
14 efficiencies, perhaps, and definitely some resource
15 needs of the Osteopathic Board. So no matter what
16 happens, I think those things need to be addressed.

17 We have members, again, who write in. I
18 have a comment from Don Hankinson here who says, "I've
19 had experience with similar issues, locally and
20 nationally. Among them, the merger of our beloved
21 osteopathic hospital with Maine Medical Center, and
22 they've alerted me to the fact that the amalgamation of
23 MD and DO organizations seems to often work out to the
24 detriment of our profession."

25 So, you know, there are some, as I said,

1 concerns. I know we've talked about that quite a bit.
2 We continue to hear those. And, again, I think we're
3 all kind of waiting for a substantive, you know, what
4 would it look like? I think that's what's hard to, you
5 know, comment on at this point is we don't really know,
6 and I know that's what this group is working on.

7 So, you know, we're happy to continue to
8 stay involved. I know that the Board is planning to
9 come and be at our meeting in two weeks so I appreciate
10 that, and hope that there's some good member engagement
11 there.

12 I've also spoken with our affiliate
13 nationally, the American Osteopathic Association, and
14 they were not able to be at this call, but they will be
15 submitting their comments to both boards, so I hope that
16 those can be received. And we will continue to share
17 member comments as we get them.

18 MR. MICHAUD: I have two requests of the
19 MOA, and actually anyone else. One is it would be
20 really good to have specifics. It's one thing to sit --
21 to hear a statement that we're concerned about loss of
22 identity, loss of independence, but how? You know, we
23 need to grapple with the -- with the concrete,
24 especially if we're going to go forward and put together
25 a statutory structure to propose. It's important for us

1 to hear what the problems are specifically, you know?
2 One person had this happen, another person had that
3 happen.

4 And my second request is, we would love to
5 have suggestions from the organizations on what we
6 should include in a bill because most of us have
7 never -- you know, with some exceptions, have no
8 experience in writing statutes. We don't know the
9 breadth of problems that people have faced that might be
10 solved by a particular statutory structure, and it would
11 be a great help for us if we could get that from -- from
12 the licensees for both boards actually, and the
13 organizations who represent them.

14 MS. MAHAN: Sure. And I know it was not
15 something that I was ready, prepared for tonight, but I
16 have asked a lot of my colleagues around the country for
17 that feedback, and it's something we're working on
18 compiling.

19 MR. MICHAUD: Great.

20 MS. MAHAN: So the asks are out there, and
21 we're looking at what's working in other states, perhaps
22 what's not working, what things we really want to avoid,
23 so we're working on that. And I know members are happy
24 to chime in. Again, I think what's difficult is what
25 are the questions, and what are -- you know, what are we

1 looking at -- especially for a licensee, right? Looking
2 at this meeting and saying there's an open comment, I
3 think that's great, and I appreciate you all for doing
4 that. I think a lot of folks are looking at it like,
5 well, what would I say? What do they want to hear?

6 So I think that's helpful, Peter, to say,
7 you know, let's collect some personal stories of
8 concrete examples, perhaps, of things that really are --
9 you know, things we want to avoid. And, yeah, maybe
10 some substantive -- what would work? What do we think?
11 Let's put pen to paper. I think that's fair.

12 MR. MICHAUD: We are open to both kinds of
13 comments. We're open to, we don't want this and here's
14 why. You know, these are specific reasons why we don't
15 think it's a good idea. But we're also open to, but if
16 it -- you know, if it's going in that direction, here's
17 what we would like to see in order to limit the harm, if
18 people feel that there's a harm. And I appreciate the
19 fact that you're putting those things together, and I
20 look forward to seeing them.

21 MS. MACARTHUR: Maroulla.

22 DR. GLEATON: In followup to Peter's
23 suggestion, I think it is important to hear what the
24 concerns are from people. Given, you know, the
25 increasing difficulties of having better function and

1 efficiency and maybe potentially having a combined
2 board, I'd like to hear not only what are your concerns,
3 but what are your solutions to those concerns? What
4 would you like to see if this was a combined board to
5 help us go forward in a more positive direction that
6 might accomplish and meet the needs of people with
7 concerns.

8 MS. HUNT: I think Dr. Brandt was next,
9 Kathryn Brandt.

10 DR. BRANDT: Greetings from the Falmouth --
11 hopefully this will be okay.

12 I do have a couple of --

13 MADAM REPORTER: I'm sorry, Dr. Brandt. I'm
14 having a hard time hearing you. If you could start
15 over, please.

16 DR. BRANDT: That's going to be a thing
17 because of where I am, but I think I could clarify at
18 least what Dr. Hankinson was alluding to in the concerns
19 department is there has just been a very long storied
20 history of mergers resulting in eclipsing, right? So
21 Maine Medical Center and Brighton, the hospital in
22 Portland merged, and what that resulted was the closure
23 of the osteopathic hospital, turning it into a rehab
24 center. It ranges from things like that to a merger of
25 the boards of licensure in California, now a long time

1 ago but within memory -- paid \$65 and get MD after their
2 names, and it took a great deal of effort to return that
3 identity. So that is the history that people are
4 experiencing when this comes up in discussion.

5 And then I think -- so if we start to
6 envision what -- what a good merger would look like, I
7 think there would be a lot of reassurances around that
8 not happening.

9 On perhaps a more addressable tone, you
10 know, when this idea was originally presented, we talked
11 about, you know, the standards of care are the same.
12 You know, the answer to that is most of the time, but
13 not all of the time, and there is a pervading
14 philosophy, and then also the practice of osteopathic
15 manipulation that have standards that are unique to
16 osteopathy. So we would need to see an assurance that
17 if an osteopathic physician is brought to the Board,
18 that they have a jury of their peers, if you will,
19 people that understand that culture and that process.

20 MS. MACARTHUR: Thank you, Dr. Brandt.

21 MR. MICHAUD: Dr. Brandt, this is Peter
22 Michaud.

23 Would you want the jury of their peers
24 situation to be only DOs hearing a case if a DO is
25 involved? Because right now, we have DOs, MDs and

1 public members hearing a case where a DO's involved, and
2 the case for an MD, and I'm wondering how that would
3 work, how that would look.

4 DR. BRANDT: I think that's something that,
5 you know, that we would challenge the group to do. I
6 don't think it necessarily needs to be all DOs, but,
7 again, it needs to be assurance of who has a voice, and
8 what sorts of consultations are brought in for the
9 direct expertise.

10 So I think one of the reasons that the MOA
11 has talked about wanting to stay involved and have a
12 voice is to engage in a discussion of, you know, what
13 would that look like? How many does it take, or is it
14 -- do you need someone who is certified in neuromuscular
15 medicine on the board, for example, or something like
16 that. I think that could be open to discussion.

17 DR. RYAN: Yeah. And, Dr. Brandt, this is
18 Lisa Ryan, one of the Board Members. I think just
19 informationally -- and I'm sure -- and somebody on BOLIM
20 can speak for them, but if we have something that is
21 presented to us that is sort of out of the area of
22 expertise of the members of the Board, irregardless of
23 whether they're a PA or a DO, that's what we do. We
24 seek the expertise in an area that we don't -- you know,
25 that we feel like we need more information on. So that

1 happens. Rest assured that happens currently, and I
2 presume that happens with BOLIM too.

3 DR. BRANDT: We're talking about -- need to
4 be built-in expertise all the time.

5 MS. MACARTHUR: I'm not sure I got all of
6 that. Could you repeat that, Dr. Brandt? Utoh. All
7 right.

8 Maroulla.

9 DR. GLEATON: So what I thought I heard her
10 say is that she would like to see that kind of expertise
11 on the Board consistently. And I think the -- first of
12 all, I agree totally with what Dr. Ryan just said.
13 That's what we do on BOLIM, just to let you know. It's
14 almost impossible to have expertise in every area of
15 medicine, whether we're talking osteopathic specialty
16 manipulation or specialty care, or we're talking about
17 ear, nose and throat specific surgical care. You can't
18 have that kind of person consistently sitting on any
19 given board at any given moment. And in recognition of
20 that, we consistently, and often, ask for expertise
21 reviews where we seek out that kind of person, the
22 practices in Maine most -- most often, or we seek them
23 first in the exact same area that we need to have an
24 expert weigh in on. Certainly we would want osteopathic
25 physicians to sit on the board -- on the combined board

1 just like we would want allopathic, just like we would
2 want PAs, just like we would want public members. We're
3 all equal in voices, and we all respect each other's
4 opinions, but we often have to have expertise in certain
5 areas to really do a good job, and we do that
6 consistently, almost every meeting, more than once.

7 MS. MACARTHUR: We do the same thing. Not
8 every meeting, but we do that as well.

9 Jodie Hermann.

10 DR. HERMANN: Hi there. Dr. Hermann here,
11 nice to meet everybody, and thank you for bringing us
12 in.

13 I could put my video on if you'd like --
14 there it is, start my own video.

15 So first off, thank you for having us, and
16 it's just been delightful that -- I can witness that you
17 guys are taking your assignment seriously.

18 From the osteopathic portion, I'm the
19 president of the MOA, and Amanda Mahan, who is our
20 Executive Director, has given you a good amount of
21 information. And what we've heard in general from our
22 membership is we just want to make sure we have
23 osteopathic representation. Could we keep our own
24 board? That would be, of course, lovely. We do
25 understand and empathize with the issue of cost and try

1 to, you know, put things together in order to create the
2 best possible outcome we can for the State. So we --
3 it's not that we're not seeing that. And, you know, if
4 it were reversed with -- an allopathic were coming onto
5 an osteopathic, it's an equitable representation. How
6 is that going to happen? How does that turn out? So
7 relative to the topic of discussion of specialties, yes,
8 OMM is a specialty, but the OPP part that's put into
9 everything, the Osteopathic Principals and Practice, is
10 every provider.

11 So the thing I always say to people who are
12 trying to understand, well, what's a DO? It's really
13 like we're an MD plus we do these other things, and we
14 got trained this way. So if I had the opportunity to
15 create the board, I would say, you know -- whatever the
16 number is, if we have a total of 12 board members, six
17 of them can be allopathically trained, six of them can
18 be osteopathically trained because, in general, that's
19 going to cover the smear of everything, right? And
20 then, just like we were saying, if we have a
21 specialist -- you know, we don't have an ONMM, the
22 person who's board certified in osteopathic
23 manipulation. You have a case relative to that, bring
24 somebody in or make sure somebody's on the board that's
25 able to do that.

1 What we gathered from the information of the
2 people within the osteopathic association is pretty much
3 that in a stronghold, are pretty sensitive to people
4 just smearing us around -- of course we are. Why?
5 Because it's happened. Historically it's just happened
6 all the time. So we are nervous, right? If you drowned
7 in the bath tub when you were a kid, you get a little
8 nervous in the lake. That's just the way it happens.

9 So those are some of the big drives. I
10 think it's helpful if Amanda goes back and takes another
11 look through relative to the questions you guys have
12 already previously discussed, which I'm thankful about
13 that. And I'm happy to be on any kind of, you know,
14 something something advisory committee or meeting or
15 whatever in order to help put it together. I know that
16 you guys have been handed a task again, and I'm thankful
17 that you're here taking it seriously. And if you need
18 to reach out to us, myself, Kat Brandt, Amanda Mahan,
19 we're more than happy to, you know, help you out.

20 Any questions?

21 MS. MACARTHUR: Thank you, Dr. Hermann.

22 DR. HERMANN: Thoughts? Ideas? Okay.

23 I'm assuming I should go dark again?

24 DR. GLEATON: No.

25 DR. HERMANN: Just trying to play by the

1 rules.

2 MR. MICHAUD: Thank you, Dr. Hermann. This
3 is Peter Michaud. I'll speak for myself. I think it's
4 extremely important to have members on the board who are
5 trained in osteopathic manipulative technique generally
6 because I think that a physician who is trained in OMT
7 has a stronger grounding in osteopathic principals. And
8 so I think having at least one member of the Board who
9 has that training and -- I mean you all get the
10 training, don't you, during your med school? But, you
11 know, somebody who not only was trained in med school
12 but has a real dedication to it, I guess, would be
13 helpful.

14 DR. HERMANN: I appreciate that, because
15 that shows insight, and that's absolutely correct. I am
16 board certified in ONMM, and Kat Brandt is board
17 certified through the family medicine path, and it does
18 make a difference. So I agree with you on your
19 statement.

20 MS. MACARTHUR: Maroulla.

21 DR. GLEATON: So I appreciate these
22 comments. It might be helpful if I could understand --
23 I think, you know, when we write up a statute, we can
24 certainly specify at least one member in an area that
25 you think is critical to have on a board. I don't think

1 that that would be that difficult to do. One other
2 thing that I am reminded of and I -- I think this might
3 even be in our statute that the person has to be a
4 practicing physician. They can't be somebody who's not
5 doing the work. So that would take care of somebody
6 that isn't simply trained in it, but somebody that's
7 actually working in it because I think that lends a
8 certain amount of credence and common sense and
9 practicality to the table that is necessary, especially
10 when you're judging -- you know, you're gonna judge your
11 peers, and you're gonna try to work through the
12 complaints. So that might be something else we would
13 want to have here. Not somebody that's simply trained,
14 but somebody that's actually practicing. That's just a
15 thought on my part.

16 MS. MACARTHUR: Thank you, Dr. Gleaton.

17 I've been asked to remind everybody to raise
18 your hand before turning on your video, please.

19 DR. FAY-LEBLANC: This is Dr. Fay-LeBlanc.
20 I just had a question about if the Osteopathic Board now
21 has something in their statute or bylaws about a
22 practicing provider with the board certification in
23 osteopathic manipulation, or if that would be something
24 that we would want to write in if there was a single
25 board?

1 MS. MACARTHUR: Go ahead, sorry.

2 MS. WILSON: This is Lisa Wilson, the AAG to
3 the Osteo Board. Currently, no, there's nothing in the
4 statute that specifies an -- you know, active
5 practitioner.

6 MS. WILLIS: And this is Jen Willis, I'm off
7 camera, I'm sitting next to Valerie so this is me over
8 here. There's my hand.

9 Just to follow up on that, other boards do
10 have specific types of practitioners who are identified
11 in their statute, and that's certainly something that
12 could be considered, and you could create a list of
13 appropriate specialties that you thought should be
14 represented on the board, among the actively engaged
15 practitioners. Which, Dr. Gleaton, I think that's the
16 language that you're remembering, and I think is in both
17 of your statutes right now that a practitioner who's
18 appointed to the Board has to have actively engaged in
19 the practice in the preceding five years prior to their
20 appointment. But there absolutely are models that could
21 be used to create sort of individualized seats and
22 identify a practitioner for individual specialties that
23 this -- that the group and/or the individual boards
24 thought were really important to represent in a joint
25 combined board, if that's the direction that the group

1 wants to go.

2 MS. MACARTHUR: All right. I don't have any
3 hands up, so I'm going to give my two cents.

4 As the only person who runs the paperwork
5 side, it's going to become unmanageable at some point.
6 I can pretty much assure you of that. I feel daily like
7 it's getting a little bit more and more behind me. I
8 try to keep up but -- I mean I'm working overtime every
9 -- every week without fail so I do need help. So if the
10 boards don't come together, then something is going to
11 have to change anyway on our end, and that's all I have.

12 Dr. Hermann.

13 DR. HERMANN: I think that was a great point
14 that you just brought up. And relative to the things
15 that I was saying, it was more physician representation,
16 but, of course, there's completely that whole other
17 side, the administrative side, the things that we're
18 trying to push through, things that our Osteopathic
19 Board has been discussing -- I'm sorry, the Maine
20 Osteopathic Board that we've been discussing is how can
21 you handle the workload? We don't need to overburden
22 everybody. Is it going to slow everything down? If
23 somebody gets called to the Board in February, are they
24 finally gonna show up in January the next year? How is
25 that process going to look? And I know that's up to the

1 Board in the details of that, but it's requiring funding
2 and making sure we have the appropriate support because
3 the other portions we have heard from our members is
4 that they don't really want it to slow down more.
5 Somebody had just gone through it, and it was a
6 six-month ordeal, and they were expressing how much
7 energy that takes from them as they're trying to live
8 their life but having this weigh on their shoulders. So
9 I am assuming that you guys are already looking at that.
10 And we are, of course, wanting to support whatever the
11 administrative component of that is in order to make it
12 facilitate more smoothly but not be overloaded.

13 MS. MACARTHUR: Dr. Gleaton.

14 DR. GLEATON: So maybe we need to hear
15 because it's been my impression that the Osteopathic
16 Board from the other members -- I have been at most all
17 of these meetings. I think I've missed one. And it was
18 clear to me early on that what I was hearing was the
19 Osteopathic Board is really overwhelmed, and hasn't been
20 able to handle. So I think you could look at not
21 combining these boards, but it sounds like you're going
22 to have to do something to ramp up your staff so that
23 you can have the work done in a timely fashion for your
24 members, which is fine, but that will ultimately mean
25 more money to be paid by members to be licensed. And I

1 think that's what you're looking at. And we are pretty
2 efficient on our side. Is it perfect? We would try
3 hard -- we always try to work hard on our side to do
4 that, and we would hope that our osteopathic colleagues
5 have a similar -- and work towards those goals also to
6 license our licensees the most efficient way possible,
7 due diligence in handling complaints as efficiently as
8 we could because it causes people stress and harm not to
9 do so.

10 MS. MACARTHUR: I do do my best to get these
11 licenses out as timely as I possibly can. The concern
12 -- the challenge for me is that it's not just licenses,
13 it's literally everything, and there's going -- I mean
14 there's going to be a time when I'm going to miss
15 something, I'm going to fail somewhere, and I don't want
16 that to happen. I also feel like -- sorry to take over
17 like this. I also feel like I don't think I need a
18 whole lot of help. If the boards did combine -- and I'm
19 hearing a little bit of it sounds like some may think
20 the MD board is going take the DO board, and that's just
21 not going to happen, it's going to be an equal thing.
22 If I have help with the other things like contracts and
23 things that Maureen helps me with so much, I think I
24 could do the DO board -- most of it myself. So -- yeah,
25 that's what I've got.

1 Dr. Hermann.

2 DR. HERMANN: Hi. Yeah, and thank you for
3 sharing that. I have not seen the stat -- I have not
4 seen the statistic sheets nor the money flow sheets, but
5 as far as I understand, we get much less funding for the
6 Osteopathic Board relative to help, et cetera. So I
7 know that's one reason why she's feeling overwhelmed and
8 it's just we don't have any money to buy -- to give
9 somebody another job to help her out. So in that --
10 again, I see the financial purpose, and the way it would
11 streamline a lot of things and, you know, I feel
12 terrible that she's under water. And we had this person
13 who had been a physician for decades. I could -- that's
14 just somebody being in their position for a long period
15 of time. So it's finance also that's hurting the
16 ability for the job to get done.

17 I'm going to be quiet. I think Amanda
18 probably has some good information.

19 MS. MACARTHUR: Amanda, go ahead.

20 MS. MAHAN: Oh, sorry. Not able to put the
21 video on, I guess.

22 I just wanted to chime in as someone who's
23 watched the Osteopathic Board for many years. I've been
24 at this, I think, about nine years now. It's a lot of
25 work to do what Rachel does so I do want to acknowledge

1 that, and thank her for sticking with it. We sort of
2 have known this cliff is coming and, in fact, some of us
3 have raised the resource issue several times. Rachel
4 should have more help, a hundred percent, that is what
5 we all agree. We want a well-resourced board that works
6 efficiently. I think just to make that clear, we do not
7 want to stand in the way of a board that works, and a
8 board that gets complaints seen efficiently, fairly,
9 equitably -- people get back to practicing, hopefully,
10 the way that we all want.

11 So I just want to acknowledge that, and
12 acknowledge to Rachel that it is a ton of work to do
13 alone, and we would love to see you get the help that
14 you need in order to maintain the efficiencies. But,
15 you know, as Dr. Hermann said, we do notice the boards
16 are differently resourced, and so that is part of the
17 equation that -- it just has to get solved. Whether or
18 not this is the answer, that has to get solved. So I
19 don't have much more to say on that. I just want to
20 thank Rachel, again, for sticking it out and, you know,
21 say that we all agree on that. Let's get you some help,
22 and let's make sure that it can run efficiently.

23 MS. MACARTHUR: I don't have any other hands
24 up. All right -- oh, Dr. Ryan.

25 DR. RYAN: Thanks, Rachel.

1 Have we gotten, other than that one
2 physician assistant comment, do you know if BOLIM or if
3 you have gotten any other kind of written comments?

4 MS. MACARTHUR: I have only gotten this one.
5 If nobody else -- oh, Dr. McFadden.

6 Dr. McFadden? No?

7 MS. HUNT: It looked like a clap, not a hand
8 raise.

9 MS. MACARTHUR: It did, it looked like a hi.
10 Okay, all right.

11 Next on the agenda is next steps.

12 MS. HUNT: The meeting invitations have been
13 sent out for the July meeting -- the June meeting. I'm
14 jumping ahead of myself.

15 MS. MACARTHUR: All right.

16 MS. OKORONKWO: Hi, this is Savannah
17 Okoronkwo. I'm also off camera, and it looks like we
18 have Donald --

19 DR. MCFADDEN: Hi. I'm a retired
20 osteopathic anesthesiologist currently living in
21 Florida.

22 When I was practicing in Maine, this issue
23 came up several times, and it became a legislative
24 issue. I think we should walk very closely here because
25 at this time, there are no osteopathic hospitals in

1 Maine, there are a lot of osteopathic physicians, and
2 this can become a legislative issue which we would have
3 no control over. That's all I have to say.

4 MS. MACARTHUR: Thank you, Dr. McFadden.

5 Dr. Ryan, did you have something?

6 DR. RYAN: In terms of next step kinds of
7 things, you know, I will be attending -- I will be at
8 the business meeting at the MOA conference on June 14th.
9 So we are -- I mean our meeting -- our board will meet
10 right before that meeting. So, you know, I would
11 encourage Amanda, you know, certainly any comments or
12 any -- and Dr. Hermann and Dr. Brandt, you know, any
13 stories, anything that you have, you know, to share with
14 me before that time or -- I think I would like to field,
15 you know, kind of concerns and questions from the
16 audience that day, but certainly if there's anything
17 that you can get, you know, to Rachel who can get to me
18 beforehand, that would be great, and I look forward to
19 kind of seeing you all in person there.

20 MS. HUNT: And then next -- oh, go ahead.

21 MS. MACARTHUR: Dr. Brewer. Oh, you're
22 muted.

23 DR. BREWER: Okay, sorry, thank you. I
24 appreciate it. Can you hear me now?

25 MS. MACARTHUR: Yes.

1 DR. BREWER: Okay, thanks.

2 So a couple of things. Several of the
3 speakers had made mention about parity on the boards,
4 and on the fact answer/question sheet that we had -- one
5 of the ideas that was put forth was having an equal
6 number of MDs and DOs on a combined board. So we
7 definitely are sensitive to that, and we're looking at
8 that. And although that's too early to make any kind of
9 a motion towards that direction because we really don't
10 know what we're working with yet, that definitely was
11 part of the ballgame, to make sure that there's parity
12 with both of the professions and they're equally
13 represented. So some of the fears -- and I absolutely
14 can appreciate those, having -- being one of the senior
15 members here, can appreciate the angst from prior
16 confrontations that we had well in the past. So that
17 issue of parity and equality and having an equal say at
18 the table is obviously a very important one.

19 Amanda or Dr. Hermann, I wanted to ask you,
20 do we have or do you have any sort of a feel, a straw
21 pull, if you will, about how many members are feeling,
22 you know, personal, you know, issues about doing a
23 combination board, and what their reasons are? And do
24 we have any numbers at all that we're looking at with
25 regards to the entire organization? Anything like that

1 at all? That was my couple of questions, thanks.

2 MS. MAHAN: Dr. Brewer, I'm hesitating to
3 respond because I don't really have a good answer for
4 you. We haven't taken a straw pull, as you say. It's
5 been discussed, and certainly we could, but, you know,
6 we've heard from dozens of members who have strong
7 feelings, but it's hard to say if that's the true
8 feeling of the group. So that's sort of -- that's what
9 we have. So we have some anecdotes, but we haven't
10 taken a poll, and that could be a conversation for sure.

11 I would love to ask a clarifying question,
12 if I could, in response to Dr. Ryan's comments about --
13 I know the board meeting for the Osteopathic Board is on
14 the 12th. I will be at the Samoset on the 12th. I'm
15 just a little bit confused on the workings of this
16 group, if there's a vote that's going to be taken or if
17 there's a time limit, responses need to come in before
18 that time? I'm wondering what does that mean for us?

19 MS. HUNT: Is that taking place in July?

20 MS. MACARTHUR: What's that?

21 MS. HUNT: The vote.

22 MS. MACARTHUR: Oh, I don't know about that.

23 MS. HUNT: For July, the July meeting.

24 MS. MACARTHUR: So apparently there's a vote
25 in July?

1 MS. HUNT: I believe each board is going to
2 bring that to their board meeting, but we do have a
3 meeting in June that is scheduled for June 25th at 5:30
4 in which I'm sure that that will be discussed.

5 MS. MACARTHUR: That must be something from
6 the last meeting that I missed.

7 Dr. Ryan.

8 DR. RYAN: Yeah. I mean I think, Amanda,
9 just for clarification, we're not having any vote or
10 making, you know, any recommendations for our June
11 meeting. I think we really wanted to be present at the
12 -- at the MOA meeting and kind of get more feedback and
13 more information, you know, from the organization and
14 from members who are in attendance. We don't have a
15 set, you know, agenda. I'm just sort of speaking as
16 vice chair of the Board because our chair isn't here.
17 We don't have any set time frame. You know, I think
18 that, you know, from BOLIM and from our perspective, you
19 know, if we make a decision that we want to move forward
20 with a recommendation to merge the boards, somewhat akin
21 to what Dr. McFadden was alluding to, we feel that we
22 need to present -- if we choose that path, then we need
23 to present what that is going to look like so that we're
24 not -- so that we are sort of driving the ship, if you
25 will, and not letting the legislature kind of make a

1 decision of what that combined board would look like.
2 So we're thinking that in order to meet our deadlines,
3 you know, we have to start really asking both boards the
4 questions of, do we want to move forward with that, or
5 do we want to remain two separate boards, and looking
6 that we need to do that sometime probably, you know, by
7 the end of this summer.

8 MS. MAHAN: Thank you, that's helpful.

9 MS. MACARTHUR: Peter, go ahead.

10 MR. MICHAUD: It's sort of an odd question
11 how we move forward because it's hard to know if this
12 group generally thinks merger is a good idea without
13 having a merger structure to look at. So I don't think
14 we can vote yes, we recommend merger. I guess if we say
15 no, we don't recommend merger, then it stops there. But
16 I think the first indication of the sense of this
17 workgroup should be something more like -- well, kind of
18 like a probable cause hearing in a legal situation where
19 we think we have enough information, enough impetus to
20 move in that general direction in order to start
21 drafting something to see what a merged structure will
22 look like. And then, as we work on the structure, as we
23 work on specific language, I think issues will come up
24 as to whether it really is a good idea or not. And, you
25 know, we may see problems halfway through the drafting

1 process that we're not seeing now, or we may get halfway
2 through the drafting process and feel like, you know,
3 this is an even better idea than I thought two months
4 ago. So I'd like to see us sort of start with just
5 getting a sense of whether we ought to work on drafting,
6 and then moving into the drafting process, rather than
7 taking a vote as to whether we think merger is good or
8 merger is bad.

9 MS. MACARTHUR: Thank you, Mr. Michaud.

10 All right.

11 So the next meeting is June -- I'm sorry --
12 25th was it?

13 MS. HUNT: Yes, June 25th at 5:30. Just a
14 reminder that all of the documents will be on the BOLIM
15 website, and I believe on the Osteo website as well.

16 MS. MACARTHUR: Yes, it will link to the
17 same page.

18 All right. Do we have to vote for
19 adjournment?

20 MS. LATHROP: No.

21 MS. MACARTHUR: No? Okay.

22 DR. GLEATON: If we are in a meeting and
23 it's a public meeting and you started it, let's just
24 make sure a motion to adjourn, okay?

25 (Motion made.)

1 DR. RYAN: It was seconded by Dr.
2 Fay-LeBlanc.

3 DR. GLEATON: Everybody in favor, raise your
4 hand or say something.

5 (Members Indicating.)

6 Anybody opposed?

7 Okay. Have a great weekend and day.

8 DR. RYAN: Thank you everybody.

9 DR. BREWER: Thank you all. Thanks for your
10 comments.

11 (Whereupon, the above-named meeting was adjourned at
12 6:31 p.m.)

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CERTIFICATE

I, Debra J. Fusco, a Notary Public in and for the State of Maine, hereby certify that on the 28th day of May, 2025, that the foregoing is a true and accurate record as taken by me by means of computer-aided machine shorthand.

I further certify that I am a disinterested person in the event or outcome of the aforementioned cause of action.

IN WITNESS WHEREOF, I have hereunto set my hand this 28th day of May, 2025.

Debra J. Fusco

Court Reporter/Notary Public

My Commission expires: February 23, 2030

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				C California ^[1] - 17:25 camera ^[4] - 8:18, 26:7, 32:17 cameras ^[2] - 3:10, 3:11 car ^[1] - 13:1 care ^[6] - 10:21, 11:5, 18:11, 20:16, 20:17, 25:5 case ^[4] - 18:24, 19:1, 19:2, 22:23 cases ^[1] - 13:11 causes ^[1] - 29:8 cautioned ^[2] - 3:21, 4:2 cell ^[1] - 3:17 center ^[1] - 17:24 Center ^[2] - 13:21,

17:21 cents ^[1] - 27:3 certain ^[2] - 21:4, 25:8 certainly ^[6] - 20:24, 24:24, 26:11, 33:11, 33:16, 35:5 CERTIFICATE ^[1] - 40:1 certification ^[1] - 25:22 certified ^[4] - 19:14, 22:22, 24:16, 24:17 certify ^[2] - 40:4, 40:9 cetera ^[1] - 30:6 Chair ^[1] - 2:12 chair ^[2] - 36:16 challenge ^[2] - 19:5, 29:12 challenges ^[2] - 10:10, 11:5 chance ^[2] - 9:18, 9:19 change ^[2] - 10:11, 27:11 changed ^[1] - 10:13 chat ^[1] - 3:13 chime ^[2] - 15:24, 30:22 choose ^[1] - 36:22 Christine ^[1] - 5:21 Christopher ^[1] - 4:22 clap ^[1] - 32:7 clarification ^[1] - 36:9 clarify ^[1] - 17:17 clarifying ^[1] - 35:11 clear ^[2] - 28:18, 31:6 clerk ^[2] - 2:22, 3:10 click ^[1] - 9:5 cliff ^[1] - 31:2 closely ^[1] - 32:24 closure ^[1] - 17:22 colleagues ^[3] - 10:22, 15:16, 29:4 collect ^[1] - 16:7 combination ^[1] - 34:23 combine ^[1] - 29:18 combined ^[6] - 17:1, 17:4, 20:25, 26:25, 34:6, 37:1 combining ^[3] - 10:6, 11:1, 28:21 coming ^[3] - 13:2, 22:4, 31:2 comment ^[8] - 4:14, 8:15, 9:16, 9:25, 13:18, 14:5, 16:2, 32:2 commentary ^[1] - 11:7 comments ^[14] - 7:9, 7:12, 7:17, 7:21,	7:25, 14:15, 14:17, 16:13, 24:22, 32:3, 33:11, 35:12, 39:10 Commission ^[1] - 40:20 committee ^[1] - 23:14 common ^[1] - 25:8 compiling ^[1] - 15:18 complaints ^[3] - 25:12, 29:7, 31:8 completely ^[1] - 27:16 component ^[1] - 28:11 computer ^[1] - 40:6 computer-aided ^[1] - 40:6 concern ^[1] - 29:11 concerned ^[3] - 13:5, 13:7, 14:21 concerns ^[8] - 13:4, 14:1, 16:24, 17:2, 17:3, 17:7, 17:18, 33:15 concrete ^[2] - 14:23, 16:8 conduct ^[1] - 4:4 conducted ^[1] - 3:12 conducting ^[1] - 4:5 conference ^[1] - 33:8 confirmation ^[1] - 11:4 confrontations ^[1] - 34:16 confused ^[1] - 35:15 confusion ^[1] - 11:2 Consequently ^[1] - 10:15 considered ^[1] - 26:12 consist ^[1] - 4:13 consistently ^[4] - 20:11, 20:18, 20:20, 21:6 consultations ^[1] - 19:8 contacted ^[2] - 10:8, 12:15 content ^[1] - 9:21 continue ^[3] - 14:2, 14:7, 14:16 contracts ^[1] - 29:22 control ^[1] - 33:3 controlling ^[1] - 2:25 conversation ^[1] - 35:10 correct ^[2] - 10:24, 24:15 cost ^[1] - 21:25 country ^[1] - 15:16 couple ^[4] - 12:25, 17:12, 34:2, 35:1 course ^[4] - 21:24,	23:4, 27:16, 28:10 Court ^[2] - 1:17, 40:18 cover ^[1] - 22:19 create ^[4] - 22:1, 22:15, 26:12, 26:21 created ^[1] - 11:6 credence ^[1] - 25:8 credentials ^[1] - 11:1 credibility ^[1] - 10:22 critical ^[1] - 24:25 culture ^[2] - 13:8, 18:19	27:19, 27:20 discussion ^[7] - 4:3, 4:7, 7:20, 18:4, 19:12, 19:16, 22:7 disinterested ^[1] - 40:9 displayed ^[2] - 2:25, 3:12 disrupt ^[1] - 3:23 DO ^[7] - 10:14, 13:23, 18:24, 19:23, 22:12, 29:20, 29:24 DO's ^[1] - 19:1 documents ^[1] - 38:14 Don ^[1] - 13:18 Donald ^[1] - 32:18 done ^[2] - 28:23, 30:16 DOs ^[4] - 18:24, 18:25, 19:6, 34:6 down ^[2] - 27:22, 28:4 dozens ^[1] - 35:6 DR ^[46] - 4:21, 4:25, 5:2, 5:10, 5:12, 5:16, 5:22, 5:24, 6:1, 6:5, 6:9, 6:11, 7:3, 7:6, 9:15, 11:15, 11:24, 12:7, 16:22, 17:10, 17:16, 19:4, 19:17, 20:3, 20:9, 21:10, 23:22, 23:24, 23:25, 24:14, 24:21, 25:19, 27:13, 28:14, 30:2, 31:25, 32:19, 33:6, 33:23, 34:1, 36:8, 38:22, 39:1, 39:3, 39:8, 39:9 Dr ^[32] - 17:8, 17:13, 17:18, 18:20, 18:21, 19:17, 20:6, 20:12, 21:10, 23:21, 24:2, 25:16, 25:19, 26:15, 27:12, 28:13, 30:1, 31:15, 31:24, 32:5, 32:6, 33:4, 33:5, 33:12, 33:21, 34:19, 35:2, 35:12, 36:7, 36:21, 39:1 drafting ^[5] - 37:21, 37:25, 38:2, 38:5, 38:6 drives ^[1] - 23:9 driving ^[1] - 36:24 drowned ^[1] - 23:6 dual ^[1] - 11:12 due ^[1] - 29:7 during ^[2] - 3:22, 24:10 duties ^[1] - 2:23	E e-mail ^[5] - 8:9, 9:23, 10:4, 12:12, 12:13 e-mailing ^[1] - 9:22 ear ^[1] - 20:17 early ^[2] - 28:18, 34:8 eclipsing ^[1] - 17:20 efficiencies ^[2] - 13:14, 31:14 efficiency ^[1] - 17:1 efficient ^[2] - 29:2, 29:6 efficiently ^[4] - 29:7, 31:6, 31:8, 31:22 effort ^[1] - 18:2 either ^[1] - 3:4 electronic ^[3] - 2:21, 3:4, 7:13 empathize ^[1] - 21:25 encourage ^[1] - 33:11 end ^[2] - 27:11, 37:7 ended ^[1] - 12:4 energy ^[1] - 28:7 engage ^[2] - 4:2, 19:12 engaged ^[2] - 26:14, 26:18 engagement ^[1] - 14:10 entire ^[1] - 34:25 envision ^[1] - 18:6 equal ^[4] - 21:3, 29:21, 34:5, 34:17 equality ^[1] - 34:17 equally ^[1] - 34:12 equation ^[1] - 31:17 equitable ^[1] - 22:5 equitably ^[1] - 31:9 err ^[1] - 9:12 especially ^[3] - 14:24, 16:1, 25:9 established ^[1] - 3:7 et ^[1] - 30:6 evening ^[3] - 2:5, 7:9, 9:20 event ^[1] - 40:10 exact ^[2] - 12:16, 20:23 example ^[1] - 19:15 examples ^[1] - 16:8 exceptions ^[1] - 15:7 Executive ^[6] - 2:6, 2:8, 6:19, 6:20, 9:2, 21:20 existing ^[1] - 11:6 experience ^[2] - 13:19, 15:8 experienced ^[1] - 12:8

experiencing [1] - 18:4 expert [1] - 20:24 expertise [8] - 19:9, 19:22, 19:24, 20:4, 20:10, 20:14, 20:20, 21:4 expires [1] - 40:20 expressing [1] - 28:6 extent [1] - 3:14 extremely [1] - 24:4	folks [2] - 8:11, 16:4 follow [2] - 4:12, 26:9 followup [1] - 16:22 force [1] - 3:10 foregoing [1] - 40:5 forth [2] - 7:20, 34:5 forward [8] - 13:12, 14:24, 16:20, 17:5, 33:18, 36:19, 37:4, 37:11 four [1] - 3:13 frame [1] - 36:17 frustrated [1] - 10:23 function [3] - 3:13, 3:14, 16:25 funding [2] - 28:1, 30:5 Fusco [3] - 1:17, 40:3, 40:17	23:11, 23:16, 28:9	history [2] - 17:20, 18:3 Holly [1] - 4:24 honor [1] - 13:4 hope [4] - 3:1, 14:10, 14:15, 29:4 hopefully [2] - 17:11, 31:9 hopes [1] - 7:9 hospital [3] - 13:21, 17:21, 17:23 hospitals [1] - 32:25 host [2] - 2:22, 3:10 hundred [2] - 11:20, 31:4 Hunt [3] - 2:8, 6:19, 9:1 HUNT [13] - 9:1, 11:17, 12:16, 12:20, 17:8, 32:7, 32:12, 33:20, 35:19, 35:21, 35:23, 36:1, 38:13 hurting [1] - 30:15	individualized [1] - 26:21 individuals [4] - 7:9, 7:11, 7:15, 9:18 information [9] - 7:19, 8:12, 9:18, 19:25, 21:21, 23:1, 30:18, 36:13, 37:19 informationally [1] - 19:19 input [2] - 7:8, 9:12 insight [1] - 24:15 intended [1] - 7:19 interested [2] - 3:2, 8:14 introductions [1] - 4:14 invitations [1] - 32:12 involved [4] - 14:8, 18:25, 19:1, 19:11 irregardless [1] - 19:22 issue [8] - 12:10, 12:11, 21:25, 31:3, 32:22, 32:24, 33:2, 34:17 issues [3] - 13:19, 34:22, 37:23
F	G	H	I	J
faced [1] - 15:9 facilitate [1] - 28:12 fact [4] - 13:22, 16:19, 31:2, 34:4 fail [2] - 27:9, 29:15 fair [1] - 16:11 fairly [1] - 31:8 Faith [1] - 6:21 Falmouth [1] - 17:10 family [1] - 24:17 Fanjoy [1] - 4:24 FANJOY [1] - 4:25 FAQ [1] - 7:10 far [1] - 30:5 fashion [1] - 28:23 favor [2] - 9:9, 39:3 Fay [3] - 5:1, 25:19, 39:2 FAY [2] - 5:2, 25:19 Fay-LeBlanc [3] - 5:1, 25:19, 39:2 FAY-LEBLANC [2] - 5:2, 25:19 fears [1] - 34:13 February [2] - 27:23, 40:20 feedback [2] - 15:17, 36:12 feelings [1] - 35:7 few [3] - 9:8, 11:19, 11:20 field [1] - 33:14 finally [1] - 27:24 finance [1] - 30:15 financial [1] - 30:10 fine [1] - 28:24 first [5] - 10:12, 20:11, 20:23, 21:15, 37:16 Fitts [1] - 6:22 five [2] - 3:15, 26:19 fix [1] - 12:6 Flaherty [1] - 5:5 FLAHERTY [1] - 5:6 Florida [1] - 32:21 flow [1] - 30:4	gather [1] - 7:8 gathered [1] - 23:1 General [1] - 8:19 general [5] - 10:16, 11:3, 21:21, 22:18, 37:20 generally [2] - 24:5, 37:12 Gillis [1] - 6:4 GILLIS [1] - 6:5 given [6] - 8:8, 10:18, 16:24, 20:19, 21:20 Gleaton [6] - 4:20, 7:3, 9:16, 25:16, 26:15, 28:13 GLEATON [13] - 4:21, 7:3, 7:6, 9:15, 11:15, 11:24, 16:22, 20:9, 23:24, 24:21, 28:14, 38:22, 39:3 goals [1] - 29:5 gonna [3] - 25:10, 25:11, 27:24 grapple [1] - 14:23 great [8] - 8:16, 15:11, 15:19, 16:3, 18:2, 27:13, 33:18, 39:7 greetings [1] - 17:10 Gregory [1] - 5:7 ground [1] - 3:5 grounding [1] - 24:7 group [7] - 14:6, 19:5, 26:23, 26:25, 35:8, 35:16, 37:12 guess [5] - 10:3, 12:1, 24:12, 30:21, 37:14 Gust [1] - 6:8 guys [4] - 21:17,	halfway [2] - 37:25, 38:1 hand [9] - 7:13, 8:16, 9:3, 9:5, 25:18, 26:8, 32:7, 39:4, 40:13 handed [1] - 23:16 handle [2] - 27:21, 28:20 handling [1] - 29:7 hands [5] - 8:11, 8:24, 10:3, 27:3, 31:23 Hankinson [2] - 13:18, 17:18 happy [5] - 12:24, 14:7, 15:23, 23:13, 23:19 hard [6] - 14:4, 17:14, 29:3, 35:7, 37:11 harm [3] - 16:17, 16:18, 29:8 headphones [1] - 4:9 hear [9] - 3:25, 14:2, 14:21, 15:1, 16:5, 16:23, 17:2, 28:14, 33:24 heard [5] - 13:3, 20:9, 21:21, 28:3, 35:6 hearing [7] - 4:7, 17:14, 18:24, 19:1, 28:18, 29:19, 37:18 heart [1] - 9:4 held [2] - 1:13, 2:1 help [12] - 15:11, 17:5, 23:15, 23:19, 27:9, 29:18, 29:22, 30:6, 30:9, 31:4, 31:13, 31:21 helpful [6] - 3:17, 16:6, 23:10, 24:13, 24:22, 37:8 helps [1] - 29:23 hereby [1] - 40:4 hereunto [1] - 40:13 Hermann [9] - 21:9, 21:10, 23:21, 24:2, 27:12, 30:1, 31:15, 33:12, 34:19 HERMANN [6] - 21:10, 23:22, 23:25, 24:14, 27:13, 30:2 hesitating [1] - 35:2 Hi [4] - 12:23, 21:10, 32:16, 32:19 hi [3] - 9:1, 30:2, 32:9 hints [1] - 3:17 historically [1] - 23:5	idea [5] - 16:15, 18:10, 37:12, 37:24, 38:3 ideas [2] - 23:22, 34:5 identified [1] - 26:10 identify [3] - 4:17, 8:21, 26:22 identity [3] - 13:6, 14:22, 18:3 impacted [1] - 10:21 impetus [1] - 37:19 important [6] - 13:11, 14:25, 16:23, 24:4, 26:24, 34:18 impossible [1] - 20:14 impression [1] - 28:15 IN [3] - 1:2, 1:6, 40:13 include [1] - 15:6 including [1] - 8:3 increasing [1] - 16:25 independence [1] - 14:22 indicate [2] - 4:18, 7:16 indicated [1] - 7:7 Indicating [3] - 5:16, 6:5, 39:5 indicating [14] - 4:21, 4:23, 4:25, 5:6, 5:8, 5:10, 5:12, 5:14, 5:18, 5:22, 6:3, 6:9, 6:13, 6:15 indication [1] - 37:16 individual [2] - 26:22, 26:23	Jamison [1] - 5:7 JAMISON [1] - 5:8 January [1] - 27:24 Jen [2] - 8:18, 26:6 Jennifer [1] - 6:23 job [3] - 21:5, 30:9, 30:16 Jodie [1] - 21:9 John [1] - 5:25 joint [1] - 26:24 Jonathan [1] - 5:13 judge [1] - 25:10 judging [1] - 25:10 July [5] - 32:13, 35:19, 35:23, 35:25 jumping [1] - 32:14 June [7] - 32:13, 33:8, 36:3, 36:10, 38:11, 38:13 jury [2] - 18:18, 18:23
			K	
			Kat [2] - 23:18, 24:16 Kathryn [1] - 17:9 keep [2] - 21:23, 27:8 Kelly [1] - 6:20 kid [1] - 23:7	

kind ^[13] - 12:5, 14:3, 20:10, 20:18, 20:21, 23:13, 32:3, 33:15, 33:19, 34:8, 36:12, 36:25, 37:17 kinds ^[2] - 16:12, 33:6 known ^[1] - 31:2 L lake ^[1] - 23:8 language ^[2] - 26:16, 37:23 large ^[1] - 9:10 last ^[1] - 36:6 LATHROP ^[1] - 38:20 Lathrop ^[1] - 6:22 least ^[3] - 17:18, 24:8, 24:24 LeBlanc ^[3] - 5:1, 25:19, 39:2 LEBLANC ^[2] - 5:2, 25:19 led ^[1] - 10:20 legal ^[1] - 37:18 legislative ^[2] - 32:23, 33:2 legislature ^[1] - 36:25 lends ^[1] - 25:7 less ^[1] - 30:5 letting ^[1] - 36:25 license ^[5] - 10:16, 10:17, 10:20, 12:5, 29:6 licensed ^[4] - 11:4, 11:9, 11:14, 28:25 licensee ^[1] - 16:1 licensees ^[2] - 15:12, 29:6 licenses ^[3] - 12:17, 29:11, 29:12 LICENSURE ^[1] - 1:2 licensure ^[3] - 11:2, 11:13, 17:25 Licensure ^[6] - 2:7, 2:9, 5:20, 8:20, 10:7, 10:8 life ^[1] - 28:8 limit ^[3] - 8:1, 16:17, 35:17 line ^[1] - 7:15 lines ^[2] - 3:9, 3:10 link ^[2] - 2:19, 38:16 Lisa ^[4] - 5:23, 6:24, 19:18, 26:2 list ^[2] - 8:11, 26:12 listen ^[2] - 4:9, 7:21 lists ^[1] - 10:17 literally ^[1] - 29:13 live ^[1] - 28:7	living ^[1] - 32:20 locally ^[1] - 13:19 located ^[2] - 9:6, 10:20 log ^[1] - 4:8 look ^[14] - 9:4, 14:4, 16:20, 18:6, 19:3, 19:13, 23:11, 27:25, 28:20, 33:18, 36:23, 37:1, 37:13, 37:22 looked ^[2] - 32:7, 32:9 looking ^[10] - 9:2, 15:21, 16:1, 16:4, 28:9, 29:1, 34:7, 34:24, 37:5 looks ^[1] - 32:17 losing ^[1] - 13:6 loss ^[3] - 13:6, 14:21, 14:22 love ^[3] - 15:4, 31:13, 35:11 lovely ^[1] - 21:24 Lynne ^[1] - 5:17 M MACARTHUR ^[64] - 2:5, 4:22, 4:24, 5:1, 5:3, 5:7, 5:9, 5:11, 5:13, 5:15, 5:17, 5:19, 5:23, 5:25, 6:2, 6:4, 6:6, 6:8, 6:10, 6:12, 6:14, 6:16, 7:1, 7:5, 7:7, 8:8, 8:14, 8:24, 9:14, 9:17, 10:2, 11:10, 11:19, 11:25, 12:3, 12:10, 12:21, 16:21, 18:20, 20:5, 21:7, 23:21, 24:20, 25:16, 26:1, 27:2, 28:13, 29:10, 30:19, 31:23, 32:4, 32:9, 32:15, 33:4, 33:21, 33:25, 35:20, 35:22, 35:24, 36:5, 37:9, 38:9, 38:16, 38:21 MacArthur ^[3] - 2:6, 6:19, 9:22 machine ^[1] - 40:6 MADAM ^[2] - 8:23, 17:13 Mahan ^[2] - 21:19, 23:18 MAHAN ^[6] - 12:23, 15:14, 15:20, 30:20, 35:2, 37:8 mail ^[5] - 8:9, 9:23, 10:4, 12:12, 12:13 mailing ^[1] - 9:22	main ^[1] - 13:4 MAINE ^[1] - 1:1 Maine ^[10] - 2:7, 2:8, 11:14, 13:21, 17:21, 20:22, 27:19, 32:22, 33:1, 40:4 maintain ^[1] - 31:14 maintaining ^[1] - 13:7 manipulation ^[4] - 18:15, 20:16, 22:23, 25:23 manipulative ^[1] - 24:5 Maroulla ^[6] - 4:20, 7:3, 9:16, 16:21, 20:8, 24:20 Mary ^[1] - 6:14 Mary-Anne ^[1] - 6:14 matter ^[3] - 3:2, 13:12, 13:15 Maureen ^[2] - 6:22, 29:23 McFadden ^[4] - 32:5, 32:6, 33:4, 36:21 MCFADDEN ^[1] - 32:19 McLaughlin ^[2] - 6:20, 6:21 MD ^[5] - 13:23, 18:1, 19:2, 22:13, 29:20 MDs ^[2] - 18:25, 34:6 mean ^[10] - 11:12, 11:13, 11:20, 24:9, 27:8, 28:24, 29:13, 33:9, 35:18, 36:8 means ^[1] - 40:6 med ^[2] - 24:10, 24:11 Medical ^[2] - 13:21, 17:21 MEDICINE ^[1] - 1:2 medicine ^[3] - 19:15, 20:15, 24:17 Medicine ^[3] - 2:9, 8:20, 10:7 meet ^[4] - 17:6, 21:11, 33:9, 37:2 MEETING ^[1] - 1:6 meeting ^[51] - 1:13, 1:14, 2:1, 2:2, 2:13, 2:16, 2:17, 2:19, 2:20, 2:23, 3:3, 3:6, 3:8, 3:11, 3:15, 3:16, 3:20, 3:21, 3:22, 3:23, 3:24, 4:1, 4:8, 4:12, 7:8, 7:10, 7:16, 14:9, 16:2, 21:6, 21:8, 23:14, 32:12, 32:13, 33:8, 33:9, 33:10, 35:13, 35:23, 36:2, 36:3, 36:6, 36:11, 36:12, 38:11, 38:22, 38:23, 39:11 meetings ^[1] - 28:17 Melissa ^[1] - 6:2 Member ^[1] - 2:10 member ^[5] - 10:15, 14:10, 14:17, 24:8, 24:24 members ^[27] - 2:15, 3:20, 3:25, 4:6, 4:11, 6:18, 7:20, 7:22, 8:2, 9:25, 12:25, 13:5, 13:17, 15:23, 19:1, 19:22, 21:2, 22:16, 24:4, 28:3, 28:16, 28:24, 28:25, 34:15, 34:21, 35:6, 36:14 Members ^[14] - 2:13, 3:8, 3:12, 3:15, 3:25, 4:2, 4:3, 4:16, 4:19, 5:20, 8:4, 8:13, 19:18, 39:5 membership ^[1] - 21:22 memory ^[1] - 18:1 mention ^[1] - 34:3 merge ^[1] - 36:20 merged ^[2] - 17:22, 37:21 merger ^[9] - 13:20, 17:24, 18:6, 37:12, 37:13, 37:14, 37:15, 38:7, 38:8 mergers ^[1] - 17:20 Michaud ^[6] - 6:2, 6:6, 9:7, 18:22, 24:3, 38:9 MICHAUD ^[15] - 6:3, 6:7, 8:6, 9:7, 11:8, 11:12, 11:21, 12:2, 12:19, 14:18, 15:19, 16:12, 18:21, 24:2, 37:10 microphone ^[1] - 3:23 might ^[5] - 15:9, 17:6, 24:22, 25:2, 25:12 mispronounce ^[1] - 5:4 miss ^[1] - 29:14 missed ^[2] - 28:17, 36:6 MOA ^[6] - 12:24, 14:19, 19:10, 21:19, 33:8, 36:12 model ^[1] - 8:22 models ^[1] - 26:20 moment ^[1] - 20:19 money ^[3] - 28:25, 30:4, 30:8 month ^[1] - 28:6 months ^[1] - 38:3 Morrisette ^[1] - 1:18	most ^[7] - 15:6, 18:12, 20:22, 28:16, 29:6, 29:24 motion ^[2] - 34:9, 38:24 Motion ^[1] - 38:25 move ^[5] - 13:12, 36:19, 37:4, 37:11, 37:20 moving ^[1] - 38:6 MR ^[19] - 4:23, 5:6, 5:8, 5:14, 6:7, 6:13, 8:6, 9:7, 11:8, 11:12, 11:21, 12:2, 12:19, 14:18, 15:19, 16:12, 18:21, 24:2, 37:10 MS ^[93] - 2:5, 4:22, 4:24, 5:1, 5:3, 5:7, 5:9, 5:11, 5:13, 5:15, 5:17, 5:18, 5:19, 5:23, 5:25, 6:2, 6:3, 6:4, 6:6, 6:8, 6:10, 6:12, 6:14, 6:15, 6:16, 6:25, 7:1, 7:5, 7:7, 8:8, 8:10, 8:14, 8:17, 8:24, 9:1, 9:14, 9:17, 10:2, 11:10, 11:17, 11:19, 11:25, 12:3, 12:10, 12:16, 12:20, 12:21, 12:23, 15:14, 15:20, 16:21, 17:8, 18:20, 20:5, 21:7, 23:21, 24:20, 25:16, 26:1, 26:2, 26:6, 27:2, 28:13, 29:10, 30:19, 30:20, 31:23, 32:4, 32:7, 32:9, 32:12, 32:15, 32:16, 33:4, 33:20, 33:21, 33:25, 35:2, 35:19, 35:20, 35:21, 35:22, 35:23, 35:24, 36:1, 36:5, 37:8, 37:9, 38:9, 38:13, 38:16, 38:20, 38:21 multiple ^[1] - 11:1 Munroe ^[1] - 5:21 MUNROE ^[1] - 5:22 must ^[1] - 36:5 mute ^[7] - 3:9, 3:10, 3:18, 7:4, 7:6, 7:15, 13:2 muted ^[2] - 3:13, 33:22 muting ^[2] - 2:24 N name ^[3] - 2:5, 4:17, 5:4

named ^[1] - 39:11 names ^[1] - 18:2 Nathan ^[1] - 6:22 nationally ^[2] - 13:20, 14:13 necessarily ^[1] - 19:6 necessary ^[1] - 25:9 need ^[19] - 10:23, 12:13, 13:16, 14:23, 18:16, 19:14, 19:25, 20:3, 20:23, 23:17, 27:9, 27:21, 28:14, 29:17, 31:14, 35:17, 36:22, 37:6 needs ^[4] - 13:15, 17:6, 19:6, 19:7 nervous ^[2] - 23:6, 23:8 Nesin ^[1] - 5:9 NESIN ^[1] - 5:10 neuromuscular ^[1] - 19:14 never ^[1] - 15:7 next ^[10] - 4:14, 5:19, 17:8, 26:7, 27:24, 32:11, 33:6, 33:20, 38:11 Ng ^[1] - 5:11 NG ^[1] - 5:12 nice ^[1] - 21:11 nine ^[1] - 30:24 Noah ^[1] - 5:9 nobody ^[1] - 32:5 nose ^[1] - 20:17 Notary ^[1] - 40:3 notes ^[1] - 7:10 nothing ^[1] - 26:3 notice ^[4] - 1:14, 2:2, 3:3, 31:15 November ^[1] - 2:12 number ^[8] - 7:24, 9:10, 11:13, 11:15, 11:16, 12:16, 22:16, 34:6 numbers ^[1] - 34:24	21:4 Okoronkwo ^[3] - 2:21, 6:23, 32:17 OKORONKWO ^[1] - 32:16 OMM ^[1] - 22:8 OMT ^[1] - 24:6 once ^[2] - 7:14, 21:6 one ^[20] - 8:9, 8:20, 10:9, 11:3, 12:14, 14:19, 14:20, 15:2, 19:10, 19:18, 24:8, 24:24, 25:1, 28:17, 30:7, 32:1, 32:4, 34:4, 34:14, 34:18 One ^[1] - 3:7 online ^[1] - 10:16 ONMM ^[2] - 22:21, 24:16 open ^[5] - 16:2, 16:12, 16:13, 16:15, 19:16 operational ^[1] - 13:13 operator ^[1] - 2:22 opinions ^[1] - 21:4 OPP ^[1] - 22:8 opportunity ^[2] - 7:18, 22:14 opposed ^[1] - 39:6 opposite ^[1] - 12:14 option ^[2] - 9:3, 9:5 ordeal ^[1] - 28:6 order ^[7] - 16:17, 22:1, 23:15, 28:11, 31:14, 37:2, 37:20 organization ^[2] - 34:25, 36:13 organizations ^[3] - 13:23, 15:5, 15:13 organizer ^[1] - 2:24 originally ^[2] - 11:6, 18:10 Osteo ^[3] - 10:19, 26:3, 38:15 osteopathic ^[18] - 13:21, 17:23, 18:14, 18:17, 20:15, 20:24, 21:18, 21:23, 22:5, 22:22, 23:2, 24:5, 24:7, 25:23, 29:4, 32:20, 32:25, 33:1 Osteopathic ^[16] - 2:7, 5:20, 10:8, 10:13, 13:9, 13:15, 14:13, 22:9, 25:20, 27:18, 27:20, 28:15, 28:19, 30:6, 30:23, 35:13 osteopathically ^[1] - 22:18 osteopathy ^[1] - 18:16 ought ^[1] - 38:5	ourselves ^[1] - 8:22 outcome ^[2] - 22:2, 40:10 overburden ^[1] - 27:21 overloaded ^[1] - 28:12 overtime ^[1] - 27:8 overwhelmed ^[2] - 28:19, 30:7 own ^[2] - 21:14, 21:23 P p.m ^[3] - 1:15, 2:3, 39:12 PA ^[5] - 8:9, 10:12, 11:2, 12:5, 19:23 page ^[1] - 38:17 paid ^[2] - 18:1, 28:25 paper ^[1] - 16:11 paperwork ^[2] - 12:6, 27:4 parity ^[3] - 34:3, 34:11, 34:17 part ^[4] - 22:8, 25:15, 31:16, 34:11 participant ^[1] - 8:11 participate ^[2] - 2:13, 8:12 participating ^[1] - 3:16 Participation ^[1] - 2:11 particular ^[1] - 15:10 PAs ^[6] - 10:11, 11:4, 11:8, 11:13, 12:8, 21:2 past ^[1] - 34:16 path ^[2] - 24:17, 36:22 patient ^[2] - 10:21, 11:5 patients ^[2] - 10:22, 10:25 Paul ^[1] - 6:10 peers ^[3] - 18:18, 18:23, 25:11 pen ^[1] - 16:11 people ^[18] - 7:24, 8:3, 8:6, 9:8, 9:10, 11:22, 12:12, 15:9, 16:18, 16:24, 17:6, 18:3, 18:19, 22:11, 23:2, 23:3, 29:8, 31:9 percent ^[1] - 31:4 perfect ^[1] - 29:2 perform ^[1] - 2:23 perhaps ^[4] - 13:14, 15:21, 16:8, 18:9 period ^[1] - 30:14 person ^[18] - 2:16, 2:19, 3:4, 3:21, 4:1, 4:7, 7:13, 11:23, 15:2, 20:18, 20:21, 22:22, 25:3, 27:4, 30:12, 33:19, 40:9	personal ^[3] - 4:8, 16:7, 34:22 perspective ^[1] - 36:18 pervading ^[1] - 18:13 Peter ^[7] - 6:6, 9:7, 12:16, 16:6, 18:21, 24:3, 37:9 Peter's ^[1] - 16:22 pharmacies ^[1] - 10:24 pharmacists ^[1] - 11:3 pharmacy ^[1] - 10:15 philosophy ^[2] - 13:8, 18:14 phones ^[2] - 3:17 physician ^[8] - 10:14, 12:17, 18:17, 24:6, 25:4, 27:15, 30:13, 32:2 physicians ^[2] - 20:25, 33:1 picked ^[1] - 3:22 pieces ^[1] - 13:8 place ^[2] - 7:25, 35:19 planning ^[1] - 14:8 platform ^[1] - 2:19 play ^[1] - 23:25 plus ^[1] - 22:13 point ^[3] - 14:5, 27:5, 27:13 policy ^[1] - 2:14 Policy ^[1] - 2:11 poll ^[1] - 35:10 Ponti ^[1] - 6:14 PONTI ^[1] - 6:15 portion ^[2] - 2:22, 21:18 portions ^[1] - 28:3 Portland ^[1] - 17:22 position ^[2] - 11:22, 30:14 positive ^[1] - 17:5 possible ^[5] - 3:14, 4:13, 9:13, 22:2, 29:6 possibly ^[1] - 29:11 posted ^[3] - 2:20, 7:11, 7:23 potentially ^[1] - 17:1 practicality ^[1] - 25:9 Practice ^[1] - 22:9 practice ^[3] - 13:10, 18:14, 26:19 practices ^[1] - 20:22	practicing ^[5] - 25:4, 25:14, 25:22, 31:9, 32:22 practitioner ^[3] - 26:5, 26:17, 26:22 practitioners ^[2] - 26:10, 26:15 preceding ^[1] - 26:19 prepared ^[1] - 15:15 presence ^[2] - 4:17, 4:18 present ^[5] - 7:22, 9:19, 36:11, 36:22, 36:23 presented ^[2] - 18:10, 19:21 president ^[1] - 21:19 presume ^[1] - 20:2 pretty ^[5] - 9:9, 23:2, 23:3, 27:6, 29:1 previous ^[1] - 7:10 previously ^[2] - 12:12, 23:12 Principals ^[1] - 22:9 principals ^[1] - 24:7 probable ^[1] - 37:18 problems ^[3] - 15:1, 15:9, 37:25 process ^[6] - 13:4, 18:19, 27:25, 38:1, 38:2, 38:6 profession ^[1] - 13:24 professions ^[1] - 34:12 propose ^[1] - 14:25 provide ^[6] - 7:12, 7:17, 7:19, 7:25, 9:18, 9:21 provider ^[2] - 22:10, 25:22 providing ^[1] - 7:9 public ^[18] - 2:15, 2:18, 2:20, 3:8, 3:9, 3:20, 3:24, 4:1, 4:6, 4:14, 7:8, 8:2, 9:25, 10:16, 11:3, 19:1, 21:2, 38:23 Public ^[2] - 40:3, 40:18 pull ^[2] - 34:21, 35:4 purpose ^[2] - 7:7, 30:10 pursuant ^[3] - 1:14, 2:2, 2:14 push ^[1] - 27:18 put ^[8] - 14:24, 16:11, 21:13, 22:1, 22:8, 23:15, 30:20, 34:5 putting ^[1] - 16:19
O				
observation ^[1] - 3:8 observe ^[1] - 3:4 obviously ^[2] - 13:13, 34:18 occasion ^[1] - 10:9 occasions ^[1] - 11:1 odd ^[1] - 37:10 OF ^[2] - 1:1, 1:2 office ^[2] - 7:16, 10:22 offices ^[2] - 2:16, 4:10 often ^[5] - 12:12, 13:23, 20:20, 20:22,				

Q	regards ^[1] - 34:25 registered ^[1] - 10:12 rehab ^[1] - 17:23 relative ^[5] - 22:7, 22:23, 23:11, 27:14, 30:6 remain ^[1] - 37:5 remember ^[1] - 7:18 remembering ^[1] - 26:16 remind ^[1] - 25:17 reminded ^[1] - 25:2 reminder ^[1] - 38:14 Remote ^[1] - 2:11 remotely ^[1] - 2:13 removing ^[1] - 11:4 Renee ^[1] - 5:1 repeat ^[1] - 20:6 REPORTER ^[2] - 8:23, 17:13 Reporter ^[1] - 1:17 Reporter/Notary ^[1] - 40:18 Reporting ^[1] - 1:18 represent ^[2] - 15:13, 26:24 representation ^[3] - 21:23, 22:5, 27:15 represented ^[2] - 26:14, 34:13 request ^[2] - 3:19, 15:4 requests ^[1] - 14:18 requires ^[1] - 3:19 requiring ^[1] - 28:1 resolve ^[1] - 11:2 resource ^[2] - 13:14, 31:3 resourced ^[2] - 31:5, 31:16 respect ^[1] - 21:3 respond ^[1] - 35:3 response ^[2] - 10:1, 35:12 responses ^[1] - 35:17 rest ^[1] - 20:1 restrict ^[1] - 9:11 restricted ^[1] - 4:10 resulted ^[1] - 17:22 resulting ^[1] - 17:20 retired ^[1] - 32:19 return ^[1] - 18:2 reversed ^[1] - 22:4 reviewed ^[1] - 7:10 reviews ^[1] - 20:21 roles ^[1] - 10:14 roll ^[1] - 4:16 Ross ^[1] - 4:22 ROSS ^[1] - 4:23 rules ^[2] - 3:5, 24:1	run ^[1] - 31:22 runs ^[1] - 27:4 Ryan ^[6] - 5:23, 19:18, 20:12, 31:24, 33:5, 36:7 RYAN ^[7] - 5:24, 19:17, 31:25, 33:6, 36:8, 39:1, 39:8 Ryan's ^[1] - 35:12	shoulders ^[1] - 28:8 show ^[1] - 27:24 shows ^[1] - 24:15 side ^[6] - 9:12, 27:5, 27:17, 29:2, 29:3 sides ^[1] - 11:25 significant ^[1] - 10:21 similar ^[2] - 13:19, 29:5 simply ^[2] - 25:6, 25:13 sincere ^[1] - 3:1 single ^[1] - 25:24 sit ^[2] - 14:20, 20:25 site ^[5] - 10:17, 10:19, 10:25, 11:3, 11:16 sitting ^[2] - 20:18, 26:7 situation ^[2] - 18:24, 37:18 six ^[3] - 22:16, 22:17, 28:6 six-month ^[1] - 28:6 slow ^[2] - 27:22, 28:4 smear ^[1] - 22:19 smearing ^[1] - 23:4 Smith ^[1] - 6:12 SMITH ^[1] - 6:13 smoothly ^[1] - 28:12 solutions ^[1] - 17:3 solved ^[3] - 15:10, 31:17, 31:18 someone ^[2] - 19:14, 30:22 sometime ^[1] - 37:6 somewhat ^[1] - 36:20 somewhere ^[1] - 29:15 sorry ^[8] - 7:4, 17:13, 26:1, 27:19, 29:16, 30:20, 33:23, 38:11 sort ^[9] - 19:21, 26:21, 31:1, 34:20, 35:8, 36:15, 36:24, 37:10, 38:4 sorts ^[1] - 19:8 sounds ^[2] - 28:21, 29:19 speaker ^[1] - 8:5 speakers ^[2] - 2:24, 34:3 speaking ^[2] - 8:15, 36:15 specialist ^[1] - 22:21 specialties ^[3] - 22:7, 26:13, 26:22 specialty ^[3] - 20:15, 20:16, 22:8 specific ^[5] - 12:10, 16:14, 20:17, 26:10,	37:23 specifically ^[1] - 15:1 specifics ^[1] - 14:20 specifies ^[1] - 26:4 specify ^[1] - 24:24 spend ^[1] - 10:23 spoken ^[1] - 14:12 staff ^[4] - 4:17, 6:18, 7:17, 28:22 Staff ^[5] - 3:7, 3:16, 4:4, 4:10 stand ^[1] - 31:7 standards ^[2] - 18:11, 18:15 start ^[8] - 7:14, 8:10, 17:14, 18:5, 21:14, 37:3, 37:20, 38:4 started ^[1] - 38:23 stat ^[1] - 30:3 State ^[2] - 22:2, 40:4 STATE ^[1] - 1:1 statement ^[2] - 14:21, 24:19 states ^[1] - 15:21 statistic ^[1] - 30:4 statute ^[5] - 24:23, 25:3, 25:21, 26:4, 26:11 statutes ^[2] - 15:8, 26:17 statutory ^[2] - 14:25, 15:10 stay ^[2] - 14:8, 19:11 step ^[1] - 33:6 steps ^[2] - 4:14, 32:11 sticking ^[2] - 31:1, 31:20 still ^[1] - 13:10 stop ^[1] - 10:11 stops ^[1] - 37:15 storied ^[1] - 17:19 stories ^[2] - 16:7, 33:13 straw ^[2] - 34:20, 35:4 streamline ^[1] - 30:11 stress ^[1] - 29:8 Stringos ^[1] - 6:8 STRINGOS ^[1] - 6:9 strong ^[2] - 10:6, 35:6 stronger ^[1] - 24:7 stronghold ^[1] - 23:3 structure ^[5] - 14:25, 15:10, 37:13, 37:21, 37:22 subject ^[1] - 3:2 submitting ^[1] - 14:15 substantive ^[2] - 14:3, 16:10 suggestion ^[2] - 8:21, 16:23
R	S			
Rachel ^[9] - 2:6, 6:18, 9:22, 30:25, 31:3, 31:12, 31:20, 31:25, 33:17 raise ^[7] - 7:12, 8:15, 9:3, 9:5, 25:17, 32:8, 39:3 raised ^[4] - 8:11, 8:25, 10:3, 31:3 ramp ^[1] - 28:22 ranges ^[1] - 17:24 rather ^[1] - 38:6 RE ^[1] - 1:6 re ^[1] - 7:6 re-mute ^[1] - 7:6 reach ^[1] - 23:18 react ^[1] - 9:3 read ^[2] - 10:3, 12:22 readers ^[1] - 10:18 ready ^[1] - 15:15 real ^[2] - 13:11, 24:12 really ^[16] - 13:4, 13:9, 14:5, 14:20, 15:22, 16:8, 21:5, 22:12, 26:24, 28:4, 28:19, 34:9, 35:3, 36:11, 37:3, 37:24 reason ^[2] - 10:18, 30:7 reasons ^[3] - 16:14, 19:10, 34:23 reassurances ^[1] - 18:7 reassure ^[1] - 10:25 received ^[2] - 3:3, 14:16 recognition ^[1] - 20:19 recognize ^[1] - 13:13 recognized ^[1] - 12:9 recommend ^[2] - 37:14, 37:15 recommendation ^[1] - 36:20 recommendations ^[1] - 36:10 record ^[1] - 40:6 redirection ^[1] - 10:19 reflected ^[1] - 13:12	Sahrbeck ^[1] - 5:13 SAHRBECK ^[1] - 5:14 Samoset ^[1] - 35:14 Savannah ^[3] - 2:21, 6:23, 32:16 saw ^[1] - 7:5 scheduled ^[1] - 36:3 school ^[2] - 24:10, 24:11 screen ^[1] - 7:14 searches ^[1] - 10:16 seats ^[1] - 26:21 second ^[2] - 9:19, 15:4 seconded ^[1] - 39:1 Secretary ^[2] - 2:6, 6:19 Section ^[1] - 2:14 see ^[9] - 16:17, 17:4, 18:16, 20:10, 30:10, 31:13, 37:21, 37:25, 38:4 seeing ^[5] - 8:24, 16:20, 22:3, 33:19, 38:1 seek ^[3] - 19:24, 20:21, 20:22 senior ^[1] - 34:14 sense ^[3] - 25:8, 37:16, 38:5 sensitive ^[2] - 23:3, 34:7 sent ^[2] - 10:4, 32:13 separate ^[2] - 13:6, 37:5 seriously ^[2] - 21:17, 23:17 set ^[3] - 36:15, 36:17, 40:13 several ^[3] - 31:3, 32:23, 34:2 share ^[2] - 14:16, 33:13 sharing ^[1] - 30:3 sheet ^[1] - 34:4 sheets ^[2] - 30:4 ship ^[1] - 36:24 shorthand ^[1] - 40:7			

suggestions ^[1] - 15:5 summer ^[1] - 37:7 supervising ^[2] - 10:11, 10:14 support ^[4] - 4:5, 10:6, 28:2, 28:10 supposed ^[1] - 11:11 surgical ^[1] - 20:17 switched ^[3] - 11:25, 12:2, 12:9 symbol ^[1] - 9:4	27:8, 29:2, 29:3 trying ^[5] - 8:22, 22:12, 23:25, 27:18, 28:7 tub ^[1] - 23:7 turn ^[3] - 3:9, 3:11, 22:6 turning ^[2] - 17:23, 25:18 two ^[6] - 11:6, 14:9, 14:18, 27:3, 37:5, 38:3 type ^[1] - 12:11 types ^[1] - 26:10	35:24, 36:9, 37:14, 38:7, 38:18	written ^[1] - 32:3 wrote ^[1] - 11:23
T	U	W	Y
table ^[2] - 25:9, 34:18 task ^[1] - 23:16 technique ^[1] - 24:5 terms ^[1] - 33:6 Terranova ^[2] - 9:22, 10:4 terrible ^[1] - 30:12 thankful ^[2] - 23:12, 23:16 they've ^[2] - 12:14, 13:22 thinking ^[1] - 37:2 thinks ^[1] - 37:12 thoughts ^[1] - 23:22 three ^[1] - 3:11 throat ^[1] - 20:17 Tim ^[1] - 9:22 timely ^[2] - 28:23, 29:11 today ^[4] - 4:3, 4:5, 4:12, 12:4 today's ^[2] - 2:13, 3:2 together ^[6] - 11:9, 14:24, 16:19, 22:1, 23:15, 27:10 ton ^[1] - 31:12 tone ^[1] - 18:9 tonight ^[1] - 15:15 took ^[1] - 18:2 topic ^[1] - 22:7 total ^[3] - 8:3, 11:13, 22:16 totally ^[1] - 20:12 towards ^[2] - 29:5, 34:9 trained ^[8] - 22:14, 22:17, 22:18, 24:5, 24:6, 24:11, 25:6, 25:13 training ^[2] - 24:9, 24:10 transcribed ^[1] - 7:22 transcription ^[1] - 7:23 true ^[2] - 35:7, 40:5 try ^[5] - 21:25, 25:11,	ultimately ^[1] - 28:24 un-mute ^[1] - 7:15 un-muted ^[1] - 3:13 un-muting ^[1] - 2:24 under ^[3] - 9:3, 11:18, 30:12 unique ^[1] - 18:15 unless ^[1] - 9:20 unmanageable ^[1] - 27:5 unnecessarily ^[1] - 3:23 up ^[15] - 3:19, 3:22, 12:4, 18:4, 24:23, 26:9, 27:3, 27:8, 27:14, 27:24, 27:25, 28:22, 31:24, 32:23, 37:23 utoh ^[1] - 20:6	Waddell ^[1] - 5:15 WADDELL ^[1] - 5:16 waiting ^[1] - 14:3 walk ^[1] - 32:24 wants ^[1] - 27:1 watched ^[1] - 30:23 water ^[1] - 30:12 wave ^[1] - 7:5 website ^[3] - 2:21, 38:15 websites ^[3] - 7:11, 7:24, 9:23 week ^[1] - 27:9 weekend ^[1] - 39:7 weeks ^[1] - 14:9 weigh ^[2] - 20:24, 28:8 Weinstein ^[1] - 5:17 WEINSTEIN ^[1] - 5:18 welcome ^[1] - 12:20 well-resourced ^[1] - 31:5 WHEREOF ^[1] - 40:13 whole ^[2] - 27:16, 29:18 WILLIS ^[3] - 8:10, 8:17, 26:6 Willis ^[3] - 6:23, 8:18, 26:6 Wilson ^[2] - 6:24, 26:2 WILSON ^[2] - 6:25, 26:2 wish ^[1] - 8:7 wishing ^[2] - 7:12, 7:24 withdrawal ^[1] - 10:19 withdrawn ^[1] - 10:18 WITNESS ^[1] - 40:13 witness ^[1] - 21:16 wondering ^[2] - 19:2, 35:18 workforce ^[1] - 11:5 workgroup ^[7] - 2:16, 7:8, 7:25, 8:4, 9:20, 9:24, 37:17 Workgroup ^[1] - 7:20 workings ^[1] - 35:15 workload ^[1] - 27:21 works ^[2] - 31:5, 31:7 WORKSHOP ^[1] - 1:6 workshop ^[2] - 1:13, 2:1 write ^[3] - 13:17, 24:23, 25:24 writing ^[2] - 10:6, 15:8	year ^[1] - 27:24 years ^[3] - 26:19, 30:23, 30:24 Z Zoom ^[6] - 1:13, 2:1, 2:19, 3:7, 4:8, 7:12

May 27, 2025

Dear Mr. Terranova and Ms. MacArthur,

I am writing in strong support of combining the Board of Licensure in Medicine with the Board of Osteopathic Licensure.

As you may recall, I contacted the Boards on more than one occasion about the work challenges I have had since the decision was made to stop allowing PAs to change supervising boards. I have been a PA since 2010, first registered with BOLIM and later with the Osteopathic Board in 2016 when I changed roles and had a supervising physician who was a DO. Consequently, every time a pharmacy or a member of the general public searches for my license on-line, they are directed to the BOLIM site which lists my license as "withdrawn." Readers are not given reason for the withdrawal or easy redirection to the osteopathic board site where my license is located. *This has led to significant delays in patient care and has impacted my credibility with my patients.* My office colleagues are frustrated with the additional time they need to spend calling pharmacies and directing them to the correct site, and we have had to reassure patients of my credentials on multiple occasions.

Combining boards would resolve PA licensure confusion, allowing pharmacists and the general public to access one site for license confirmation for PAs, and removing the workforce challenges and delays in patient care that the existing two boards originally created.

Thank you.

Gretchen Preneta PA-C



TO: Members of the Maine Board of Licensure in Medicine and the Maine Board of Osteopathic Licensure

FROM: American Osteopathic Association

DATE: May 28, 2025

SUBJECT: Combined MD/DO/PA Board Feasibility Study Workgroup

On behalf of the American Osteopathic Association (AOA) and the more than 197,000 osteopathic physicians (DOs) and medical students (OMSs) we represent nationwide, we thank the Maine Board of Licensure in Medicine and the Maine Board of Osteopathic Licensure (Boards) for this opportunity to provide feedback regarding the combined MD/DO/PA Board Feasibility Study Workgroup.

The AOA shares the position of the Maine Osteopathic Association in support of the continued, *independent* existence of the allopathic (MD) and DO Boards, for the following reasons:

All DOs and MDs complete the same basic medical school education; however, DOs ***additionally*** receive **several hundred hours of training in osteopathic principles and practice** that MDs traditionally do not receive. This training allows them to provide hands-on treatment (known as osteopathic manipulative treatment, or OMT) to their patients, and approach their care from a holistic perspective that takes into account mind, body, and spirit. Their approach also focuses on the body's innate ability to restore itself to wellness.

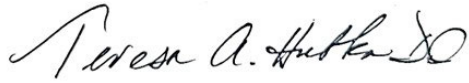
This unique osteopathic philosophy is woven throughout osteopathic medical education and training, and osteopathic competencies are assessed via the DO licensing exam series, the Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA). From a licensing and disciplinary perspective, DO boards are also uniquely well-suited to assess the competencies and qualifications of other DOs, thereby facilitating the entry and ongoing practice of qualified DOs within the community, which benefits patients.

In Maine, the Board of Osteopathic Licensure (BOL) has been safely and efficiently serving DOs and their patients since its establishment in 1973. It is **entirely self-sustaining** through application fees and fines, and does not require any money from the state to operate. Further, the BOL personally reviews each application for licensure to ensure that applicants meet the highest standards of patient care and professionalism—a safeguard that is not guaranteed should the boards be combined.

For these reasons, the AOA maintains its position that there is insufficient justification regarding the need for a feasibility study to combine the boards, which disregards the efficient and efficient functioning of the BOL. The AOA supports patient choice in medical care, and believes that separate boards play a critical role in ensuring that patients are able to continue to choose safe, high-quality medical care from either a DO or an MD.

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,

A handwritten signature in black ink, reading "Teresa A. Hubka, DO". The signature is fluid and cursive, with the "DO" at the end being more distinct.

Teresa A. Hubka, DO, FACOOG
President, AOA

CC: Robert Piccinini, DO, President-elect, AOA
Bruce Wolf, 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

Terranova, Tim E

From: Amanda Mahan <amahan@mainedo.org>
Sent: Wednesday, May 28, 2025 5:36 PM
To: MacArthur, Rachel; Terranova, Tim E
Subject: Fwd: News from the MOA: Licensing Board Merger Open Comment TONIGHT 5/28, Congrats 2025 Grads, ME Section ACOG Meeting & CME at MOA Convention

EXTERNAL: This email originated from outside of the State of Maine Mail System. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Hi Rachel & Tim,

Just FYI I wanted to share a comment I received from a member who was not able to join tonight's meeting. Similarly, you should expect written comments from our national affiliate the American Osteopathic Association from Raine Richards, who was also unable to join live.

Many Thanks,
Amanda

Amanda Mahan
Executive Director
Maine Osteopathic Association
Phone: [207-623-1101](tel:207-623-1101)
Website: www.mainedo.org



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----- Forwarded message -----

From: [REDACTED]
Date: Wed, May 28, 2025 at 4:34 PM
Subject: Re: News from the MOA: Licensing Board Merger Open Comment TONIGHT 5/28, Congrats 2025

Grads, ME Section ACOG Meeting & CME at MOA Convention

To: Maine Osteopathic Association <office@mainedo.org>

Thank you for the FYI on the pending question of merging the MOA & MMA licensing boards. I cannot be at the meeting this evening, but I would like to share a thought with you.

Given that I have had no personal participation on or with these boards, I admit that my comments lack that degree of authenticity which only experience can ascribe. Still, I want to urge a sense of caution to those considering this change,

I have had some experience with similar issues, both locally and nationally, among them the "merger" of our beloved OHM with MMC. And they have alerted me to the fact that the amalgamation of MD & DO organizations, seems to often work out to the detriment of our profession.

These words I share with you are from my heart and are spoken with a deep and abiding respect for all of you who volunteer your precious time to serve the people of Maine and our profession. I am grateful for your service and trust your best intentions. It is from a similar sense of responsibility to honor, cherish, and preserve what is of precious value in our profession for the healing of our neighbor's suffering, that I speak.

Respectfully, d

Donald V Hankinson, DO
Explorations in The Science of Osteopathy
12 Maxwell Woods Drive
Cape Elizabeth, ME 04107
207-232-4410

On Wednesday, May 28, 2025 at 03:24:32 PM EDT, Maine Osteopathic Association <office@mainedo.org> wrote:



Welcome to your MOA E-News

- **MOA News:**

- **The 114th MOA Convention is coming soon! Join us in person at the Samoset or online for 20+ CE details & to register.**

Summary of MOA Survey Feedback: Proposed Maine Licensing Board Merger

The Maine Osteopathic Association (MOA) recently [surveyed](#) licensed DOs across the state to gather feedback on the potential merger of the state's two physician licensing boards. Respondents shared their concerns, hopes, and experiences related to the [BOLIM/BOL Workgroup](#).

In the short one week response window, there were 27 individual responses, with input shared either via the survey link or to MOA staff via email. All response data can be found [here](#).

Key Themes from Responses

1. Strong Concern Over Loss of Osteopathic Identity

- Many DOs expressed deep concern that a merged board could lead to the dilution—or loss—of the osteopathic profession's identity in Maine.
- Some described the merger as a “death knell” for osteopathic medicine if not structured with safeguards for DO representation.

2. Broad Support for Maintaining Distinct Representation

- Nearly all respondents emphasized that maintaining strong, distinct osteopathic representation is **very important**.
- Suggestions included:
 - Guaranteed DO seats on any merged board
 - Separate review processes for complaints against DOs
 - Recognition of the osteopathic philosophy and training in all regulatory functions

3. Value of the Existing BOL

- Several respondents noted positive experiences with the current Maine Board of Osteopathic Licensure, citing accessibility and understanding of osteopathic practice.
- Concerns were raised about being absorbed into a system that may be more bureaucratic or less responsive to DO-specific concerns.

4. Lack of Confidence in Rationale for Merger

- Some respondents questioned the motives behind the proposed merger, suggesting it may have been initiated without sufficient input from DOs.
- Others noted the absence of clear evidence that a merger would lead to cost savings or improved efficiency.

5. Limited Experience with Other State Boards

- Most respondents indicated they did not have experience with other state licensing boards, but still emphasized the importance of preserving osteopathic oversight.
- One suggested that “The AOA Osteopathic Board of Medical Examiners (NBOME) is an excellent source for information and guidance.”

Individual Feedback Highlights

- One respondent noted: *“Maintenance of our own licensing board is CRITICAL to the survival of osteopathy in Maine.”*
 - Another shared: *“Very important. Having a dual board is another example of how DOs are treated as equals—but separate. That distinction matters.”*
-

Terranova, Tim E

From: Jacey Goddard [REDACTED]
Sent: Monday, June 9, 2025 8:01 PM
To: Terranova, Tim E
Subject: Licensing Board

EXTERNAL: This email originated from outside of the State of Maine Mail System. Do not click links or open attachments unless you recognize the sender and know the content is safe.

I wanted to directly express my significant concerns about anything that would threaten the distinct Osteopathic Licensing Board representing the licensing of Maine Osteopathic Physicians. Allopathic Physicians do not have sufficient training to adequately oversee osteopathic standard of care. Thank you for your efforts on our behalf and please reach out if you need anything from me.
Sincerely
Jacey Goddard, DO

Get [Outlook for iOS](#)

MacArthur, Rachel

From: Judith Aldrich [REDACTED]
Sent: Monday, June 9, 2025 8:20 PM
To: PFR, Osteo
Subject: DO license merger

EXTERNAL: This email originated from outside of the State of Maine Mail System. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Hi,

I'm an osteopathic physicians who's father was also an osteopathic physicians.

I prefer having a separate license.

I did have a MA medical license and found as did other osteopathic physicians that the licensing Board unfairly delays licenses to osteopathic physicians.

We are osteopathic physicians and I absolutely want our own separate licensing board.

Judith Aldrich, DO

Sent from my iPad

Terranova, Tim E

From: JohnB [REDACTED] >
Sent: Tuesday, June 17, 2025 8:03 AM
To: Ryan, Lisa
Cc: MacArthur, Rachel; Terranova, Tim E; Dr. Christine Munroe
Subject: Re: Work Group Meeting

EXTERNAL: This email originated from outside of the State of Maine Mail System. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Lisa, thanks so much for donating your time to represent the Boards' group. Really appreciated. Your questions echo info and concerns I/others have had too. Great if Tim/ Rachel can shed light on that for next meeting. Thanks again, and also for leading the meeting last week! JB
Sent from da Brew's iPhone

On Jun 17, 2025, at 7:47 AM, Ryan, DO, Lisa D [REDACTED] wrote:

. Rachel and Tim,

I spoke about the work group process at the MOA meeting last weekend and then had lunch with MOA and AOA leadership. There were questions raised that unfortunately I could not answer with regards to the behind the scenes and governmental aspect of the Boards. They also had questions about "how much it would cost" to adequately staff the BOM so that we could remain independent. Not sure if it is possible to look at what that cost would be and how that would affect the licensing fees for DO's. Is that something you both could provide for us?

Thanks and see you next week,

Lisa

Board of Licensure in Medicine - Board of Osteopathic Licensure
Workgroup
ZOOM meeting
June 25, 2025
5:31 p.m. – 6:49 p.m.

Board Members Present

Public Member Lynne Weinstein (BOLIM)
Renée Fay-LeBlanc, MD (BOLIM)
Public Member Peter Michaud, JD, RN (BOL)
Melissa Michaud, PA (BOL)
Public Member Dennis Smith, Esq. (BOL)
Public Member Mary-Anne Ponti, RN, DBA (BOL)
John Brewer, DO (BOL)
Christine Munroe, DO (BOL)
Paul Vinsel, DO (BOL)

Board Staff Present

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

Legal Counsel Present

Assistant Attorney General Jennifer Willis (BOLIM)
Assistant Attorney General Lisa Wilson (BOL)

A roll call of board members present was conducted.

Discussion

Mr. Terranova asked the workgroup for feedback regarding public comments received. Workgroup members noted that there was a high level of concern expressed in the letters regarding the risks of merging the Boards and reference to the merger of Boards in California many years ago. However, the issue in California is not applicable to the current situation or present-day relationship between MDs and DOs.

Mr. Terranova addressed a concern expressed at the May meeting that the BOL did not receive equal funding. The Boards are financed through licensing fees. BOLIM has approximately four times as many licensees as BOL and therefore generates more revenue.

Workgroup members asked about experiences in other states following Board mergers. Mr. Terranova indicated that he and Ms. MacArthur had recently spoken with Executive Directors of other Boards and the feedback was positive - it is easier because both professions follow the same rules and standards.

Mr. Michaud noted that he recently spoke with members from the New Mexico Board and received positive feedback. Initially there were some administrative difficulties, but in terms of operation the comments were positive.

Mr. Smith stated that he attended the recent Maine Osteopathic Association conference. Dr. Ryan gave

a presentation to reassure members that the workgroup is studying the feasibility of merging the Boards to report to the legislature. The American Osteopathic Association opposes a merger and opposition to a merger in Nevada was successful.

Mr. Smith said that there is a fundamental misunderstanding about the mission of the Boards and a lack of knowledge of how the Boards operate. The Boards are state agencies tasked with protecting the public. He also noted that if the Boards were to merge it would be the end of BOLIM as it has been since 1895. Both BOLIM and BOL would experience changes.

The workgroup reviewed a document prepared by Mr. Smith detailing Ms. MacArthur's responsibilities as the Executive Secretary for the BOL as well as a document illustrating how those same responsibilities are divided among ten staff members at BOLIM.

The workgroup also reviewed charts prepared by BOLIM and BOL showing the increase in the number of licensees over the past ten years. The workgroup discussed that as the number of licensees continues to grow proportionately more staff are needed to complete the work. Mr. Smith asked about the possibility of estimating the cost to staff the BOL based on the current number of licensees and a minimum of four staff members – how much would licensing fees need to increase to create and fund the additional staff positions. He stated that it is important to show stakeholders that the workgroup is listening to concerns and investigating.

BOL workgroup members discussed the size of the documents received for each Board meeting – 12,000 pages – and noted the tremendous amount of reading and preparation required for each meeting. Concerns about the potential for missing important details were discussed. BOL workgroup members expressed that Ms. MacArthur undertakes a monumental task with the current workload. Ms. MacArthur commented that she is concerned about the potential for missing something important. BOL workgroup members noted the importance of having a medical director to guide staff during the complaint process and to organize records for review by Board members.

The workgroup questioned if the current BOLIM medical director would be able to handle the additional workload if the Boards merged. This issue will need to be reviewed if the Boards move forward with a merger.

There was brief discussion about the composition of a merged Board with an equal number of MDs and DOs and committees to review complaints and conduct hearings.

Mr. Terranova asked if the workgroup members feel discussions are at the stage to take information back to the respective Boards for consideration at the July meetings to vote either to continue moving forward and create a document with specific details of what a merged board would look like and how it would operate or determine that a merger is not feasible. Workgroup members from both Boards agreed that it was time to bring the issue to the Boards for discussion.

Mr. Terranova provided an email comment from Dr. Riley and asked if any member of the public wished to make a comment. No public comment made.

The next meeting is July 23rd at 5:30 p.m.

Adjourn 6:49

Rachel MacArthur: Duties & Responsibilities

- General
 - Primary contact for all communications to the Board of Osteopathic Licensure
 - Telephone
 - Email
 - Written Communications
 - Is BOL's FOAA Contact (acknowledge receipt of request within 5 days, provide a time and costs estimate, research and locate records, coordinate with BOL's Assistant Attorney General regarding any redactions, collection of any fees, provide the requested documents, provide yearly report to the Maine FOAA Ombudsman)
 - Is BOL's Public Records Officer – responsible for maintaining BOL's records in accordance with State Archive retention schedules
 - Is required to complete mandated training in order to access Criminal Records History Information
 - Is required to register an account with the National Practitioner Data Bank and undergo training and orientation in order to ensure timely and appropriate reporting of adverse actions
 - Responds to/Coordinates with:
 - The PFR Commissioner's Office
 - State agencies (i.e. licensing boards, Office of Attorney General, DHHS Licensing, State Bureau of Identification)
 - Federal agencies (i.e. DEA, DOJ)
 - The Federation of State Medical Boards
 - The Federation Credentials Verification Service
 - Administrators in Medicine
 - Medical Professionals Health Program (of the MMA) – to include attendance at quarterly meetings and coordination regarding licensees being actively monitored by MPHP
 - Maine Osteopathic Association
 - Maine Medical Association
 - Maine Medical Facilities (private practices and hospital systems)
 - National Practitioner Data Bank
 - Responsible for maintaining and updating the BOL website
 - Responsible for ordering all office supplies
 - Responsible for creating and managing BOL contracts with vendors who provide services to the BOL (expert witnesses, hearing officers, etc.)

- Responsible for managing BOL's finances, including but not limited to payment of invoices for rent, supplies, expert witnesses and reviews, hearing officers, and payment of BOL members
- Responsible for coordinating with Maine OIT regarding the Agency Licensing Management System (ALMS), including any issues, updates.
- Responsible for supervising the Consumer Assistant Specialist
- Responsible for staffing, providing public notice of Board meetings, and creating and maintaining the minutes of Board meetings
- Licensing
 - Responsible for processing all applications for initial licensure, including the following tasks:
 - Receipt of all applications
 - Receipt and processing of all application fees
 - For EACH original license application perform the following:
 - Communicate with the applicant regarding outstanding requirements or documentation needed
 - Review Uniform Application for completeness
 - Review Maine Application Addendum for completeness
 - Obtain National exam Scores
 - Run a report for the applicant in the FCVS Physician Data Center (PDC) to determine where the applicant is or has been licensed and or has been disciplined
 - If an applicant has a disciplinary action in another jurisdiction, obtain copies of any documentation related to that action (either by downloading from the agency's website or contacting the agency and requesting the records)
 - Run a report for the applicant in the National Practitioner data Bank (NPDB) to determine if the applicant has had any medical malpractice settlements, discipline or adverse action by a licensing board, or the suspension, revocation or privileges or employment related to unprofessional conduct or incompetent practice
 - Ensure receipt of two professional references, when required
 - Assemble an electronic application file using Adobe Acrobat Pro that includes:
 - The affidavit
 - The applicant information
 - The Uniform Application and Maine Application Addendum
 - School Certification of the applicant's attendance and successful completion

- School transcripts
 - Verification of Identity Documentation (i.e. license, birth certificate, passport)
 - Verification of Completion of Postgraduate Training from the PGT Program
 - Verification of National Board Scores
 - PDC Report
 - NPDB Report
 - Combine all complete and assembled applications into a single PDF, and bookmark each application for easy access and review by the Board members.
- Responsible for processing all applications for licensure and issuing letters of qualification pursuant to the Interstate Medical Licensure Compact (IMLC), including the following tasks:
 - Criminal Background Check: Primary responsibility for complying with BOL/SBI/FBI laws and policies regarding access to and review of criminal record history for applicants for licensure pursuant to the IMLC.
 - Issuing Letters of Qualification to other licensing boards for Maine physicians seeking licensure in another jurisdiction
 - Acting as the BOL's designated Commissioner to the Interstate Medical Licensure Compact Commission
- Responsible for processing all applications for renewal of licensure
 - Placing flags on applicants with open complaints/investigations
 - Issuing Title 5 letters
 - Lifting flags and issuing license renewals following Board review
 - When directed by the Board:
 - Compose and issue letters of preliminary denial of re-licensure in coordination with the Board AAG
 - If no appeal is filed by the applicant, then issue a letter of final letter of denial to the applicant, close the application, and report the adverse licensing action to the FSMB and NPDB
- Complaints and Investigations: Assisted by AAG & Consumer Assistant Specialist
 - Responsible for processing all complaints received by the Board, to include the following tasks:
 - Saving the complaint (written or online) into an electronic file
 - If a written complaint, sending a letter to the complainant acknowledging receipt of the complaint
 - Entering a license flag in ALMS for the licensee
 - Sending the complaint to the licensee – mail or email with a cover letter explaining the complaint process and requirement to respond

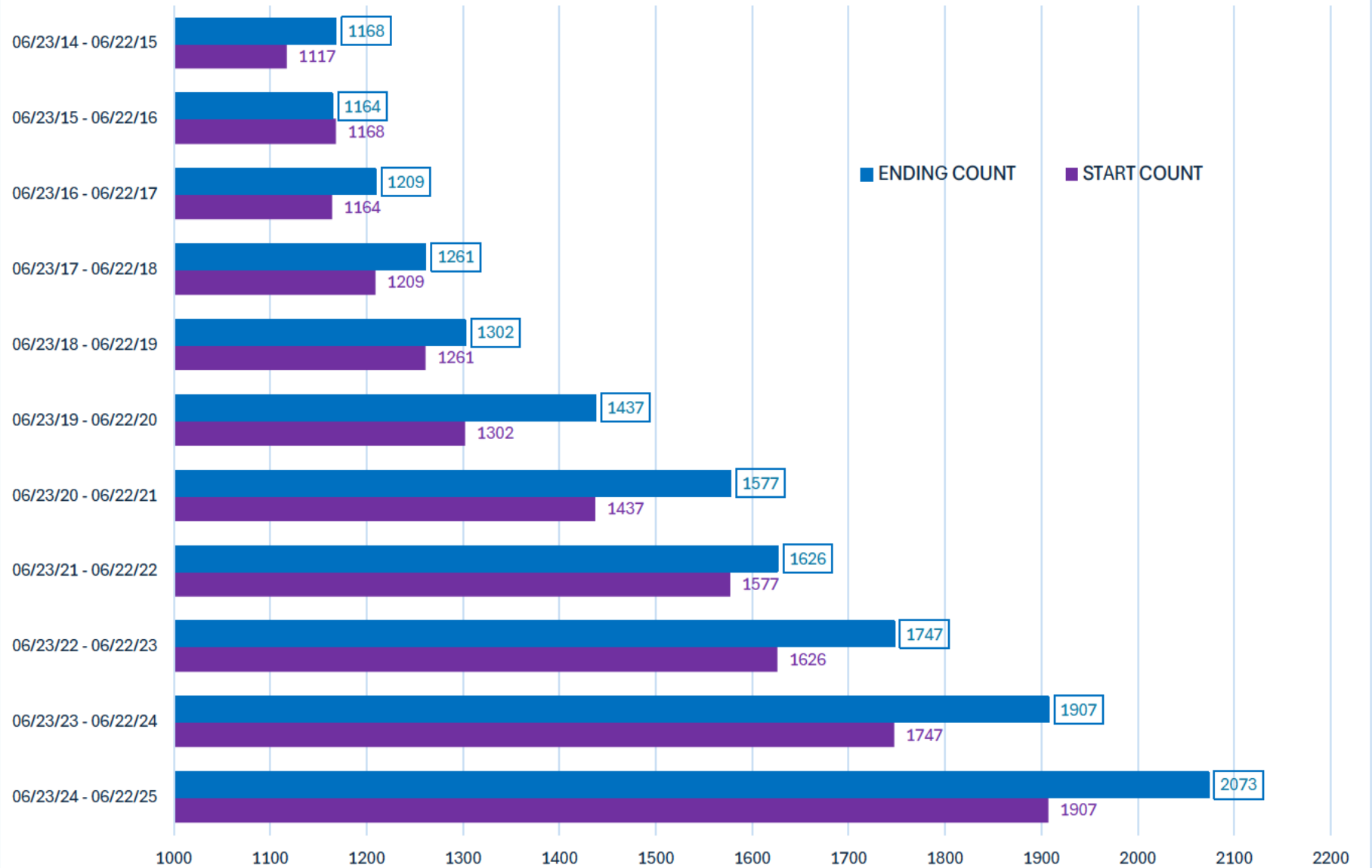
- Upon receipt of the response, save it to the electronic complaint file and provide it to the complainant (unless otherwise indicated) to provide an opportunity to submit a rebuttal
- Obtain medical records related to the complaint – to include requesting them from the licensee and/or creating and issuing a subpoena to a medical provider or medical facility
- Research the licensee for any disciplinary actions; if disciplinary actions exist then obtain copies and save them to the electronic complaint file
- Research the licensee for any previous letters of guidance; if they exist then save a copy to the electronic complaint file
- Print a copy of the licensee's licensing profile page on ALMS and save it to the electronic complaint file
- Assemble the completed electronic complaint file using Adobe Acrobat Pro – and bookmark it for ease of access and review by Board members
- Assign a Board member to be the case reporter for specific complaints
- Conduct additional investigation when directed by the Board following initial review of a complaint – and ensure timely follow-up
- When the Board votes to dismiss a complaint:
 - Closing the complaint following a vote to dismiss by the Board
 - Sending a closure of complaint letter to the licensee/complainant
 - Removing the license flag in ALMS
- When the Board votes to hold an Informal Conference:
 - Sending a notice of informal conference to the licensee/complainant
 - Scheduling the informal conference
 - Conducting any additional follow-up to the informal conference as directed by the Board
- When the Board votes to hold an Adjudicatory Hearing:
 - Contact the hearing officer
 - Assist AAG with exhibit preparation
 - When requested, secure a transcriptionist for the hearing
- When the Board votes to impose a summary suspension:
 - Notify the licensee of the summary suspension
 - Send the licensee a copy of the Board Order of Suspension
 - Report the adverse action to the FSMB and the NPDB
- When the Board votes to offer a Consent Agreement:
 - Upon acceptance by the licensee, provide a completed copy to the licensee
 - Save a copy of the Consent Agreement to the electronic complaint file
 - Report the adverse action to the FSMB and the NPDB
 - Close the complaint file
 - When required, create an electronic monitoring file for the licensee

- Responsible for processing all mandated and other reports made to the BOL pursuant to 5 MRS Sections 2505 and 2506, to include:
 - Follow-up with the reporting individual or entity to request and obtain additional information related to the report, including:
 - Identification of witnesses/patients
 - Reports and other documents related to the report
 - Medical records related to the report
 - Police Reports
 - Court Records
 - Urine/Blood Test Results
 - Creating an electronic investigative file
 - Assigning a Board member as case reporter for the investigation
 - Upon review by the Board:
 - Close the investigation
 - Conduct additional investigation/follow-up
 - Initiate a complaint – and draft and then issue a complaint to the licensee and create an electronic complaint file and then follow the complaint processes
- Rule Making
 - Is BOL's primary rule making administrator
 - Responsible for knowledge of and completion of all documentation required for agency rule making
 - Responsible for ensuring publication of proposed rules
 - Responsible for collecting writing and verbal responses to proposed rules
 - Responsible for ensuring the process of a proposed rule according to statutory time requirements
- Legislation
 - Is BOL's representative to the PFR Legislation Team
 - Is responsible for tracking legislation that may impact BOL – and provide updates to the Board
 - Is responsible for providing PFR with a summary of a bill that may impact BOL
 - Is responsible for completing a Legislative Appraisal Form (LAF) following action on a bill by a legislative committee
 - Is responsible for submitting written testimony to the legislature on any bills that may impact BOL

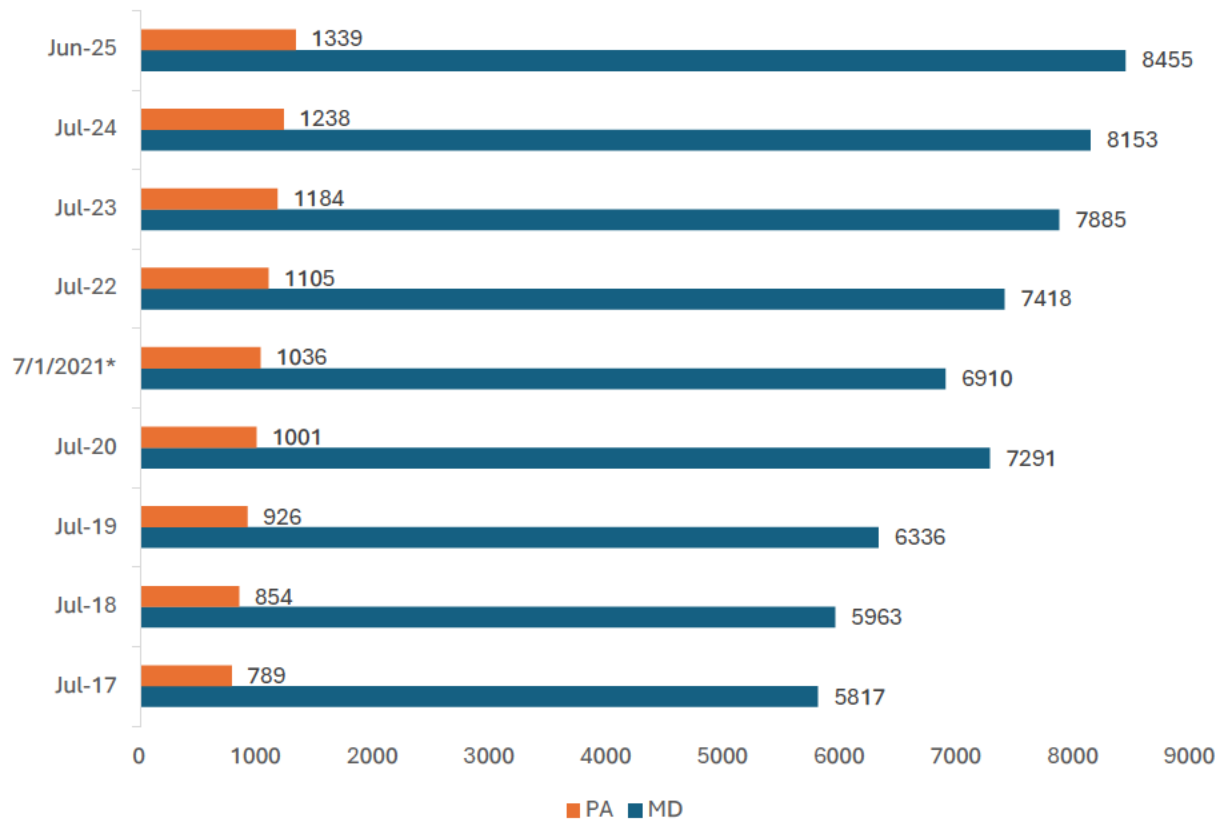
BOLIM Staff & Duties: 10 People

- Executive Director: Overall responsibility for the administration of the Board's Mission
- Assistant Executive Director: Responsible for overall administration in the absence of the Executive Director
- Licensing Staff Supervisor: Supervises two licensing specialists who are solely responsible for licensing and re-licensing of all individuals with the Board
- Complaint Coordinator: Supervises two staff (Investigative Secretary and Consumer Assistant Specialist) who are responsible for processing all complaints and investigations filed with the Board
- Medical Director: Works with Board staff to identify and bookmark medical records relevant to complaints and investigations. Primary responsibility for conducting and presenting investigations to the Board regarding mandated reports and medical malpractice settlements/judgments.
- Secretary: Primary responsibilities include: BOLIM's Records Officer; BOLIM's Rule Making; Drafting Board Meeting Minutes; Processing contracts and other invoices.

DO Licensee Count by Year June 23 - June 22



MD/PA Active Licensee Count by Year July 1st



From: James N Riley, DO [REDACTED]
Sent: Friday, June 20, 2025 7:13 PM
To: MacArthur, Rachel <Rachel.MacArthur@maine.gov>
Cc: 'Amanda Mahan' <amahan@mainedo.org>; President@mainedo.org
Subject: Licensure Boards Proposed Merger

EXTERNAL: This email originated from outside of the State of Maine Mail System. Do not click links or open attachments unless you recognize the sender and know the content is safe.

The public, the body politic, has a right and a duty to regulate the practice of certain professions, including medical professions. However, there is no duty, no right to merge medical professions.

In the USA, medical professional regulation by government is done largely through state licensing boards, which have broad authority. The funding for this regulation is in considerable part through license fees paid by the licensees.

The State of Maine has two medical licensing boards, as do many US states - one for MDs, and one for the smaller and more recently established group, DOs, “osteopaths”. Historically, the very existence of DOs as a medical profession was very hard fought. The MD profession fought hard to keep DOs from being licensed at all, but the DOs prevailed, and received the Maine Board of Osteopathic Licensure.

In Maine as elsewhere in the USA, over the last 100 years, the two medical professions have evolved to become much more collegial, much more cooperative, and much more mutually supportive. Nowadays, they usually lobby the state government cooperatively. But they are distinct. And the Maine DOs do not want to be subsumed within the 4 times larger Maine MD profession. They claim that their profession remains distinctive in ways that do make a professional difference. And perhaps they are the best judges of that. A similar opinion is reflected in many other US states.

Now there is a proposal to merge the DO Maine Board of Osteopathic Licensure with the MD Board of Licensure in Medicine. In terms of state regulation, this would eliminate the

status of DOs as a separate profession. And in practical terms, they would be governed by the 4 times larger MD profession. That would be unfair, and unjust.

The public, the body politic, has a right and a duty to regulate the practice of certain professions, including medical professions. However, there is no duty, no right to merge medical professions.

I hope that you will give this serious attention.

Thank you,

James Riley, DO

East Bank Health

Brewer, Maine

Board of Licensure in Medicine - Board of Osteopathic Licensure
Workgroup
ZOOM meeting
July 23, 2025
5:31 p.m. – 6:59 p.m.

Board Members Present

Public Member Lynne Weinstein (BOLIM)
Renée Fay-LeBlanc, MD (BOLIM)
Public Member Peter Michaud, JD, RN (BOL)
Melissa Michaud, PA (BOL)
Public Member Dennis Smith, Esq. (BOL)
Public Member Mary-Anne Ponti, RN, DBA (BOL)
John Brewer, DO (BOL)
Paul Vinsel, DO (BOL)
Lisa Ryan, DO (BOL)

Board Staff Present

Executive Director Timothy Terranova (BOLIM)
Assistant Executive Director Valerie Hunt (BOLIM)
Administrative Assistant Maureen Lathrop (BOLIM)
Medical Director Paul Smith, MD (BOLIM)
Executive Secretary Rachel MacArthur (BOL)

Legal Counsel Present

Assistant Attorney General Jennifer Willis (BOLIM)
Assistant Attorney General Lisa Wilson (BOL)

A roll call of board members present was conducted.

Discussion

Mr. Terranova invited workgroup members to report on discussions at their respective Board meetings regarding continuing with the process to determine the feasibility of merging the two Boards. Ms. Weinstein reported positive feedback during the discussion at the July BOLIM meeting. Dr. Vinsel reported a robust discussion at the July BOL meeting regarding negative feedback from osteopathic physicians in Maine; however, most of the comments did not address the issues of staffing and funding of BOL. Some commenters noted concerns that merging the two Boards would result in one license type rather than maintaining allopathic and osteopathic licenses. Both Boards voted to continue with the process.

Mr. Smith gave a brief overview of the draft document he prepared that could form the basis of a combined Board. The draft outlines a Board comprised of seventeen members – five allopathic physicians, five osteopathic physicians, four physician associates and three public members. It also proposes establishing complaint/investigation committees to review and determine disposition of complaints and a separate hearing committee to conduct adjudicatory hearings. Members on the hearing panel would not be members of the complaint/investigation committees.

Mr. Terranova noted that the draft document indicates that the composition of the complaint/investigation committees would change based on the profession of the licensees – more

osteopathic physicians on the committee when reviewing complaints against osteopathic physicians and likewise with allopathic physicians and physician associates. He indicated that that composition may not work due to the number of complaints the Boards receive. BOLIM reviews 25-30 complaints per month while BOL reviews 5-10 per month. This would create a heavier workload for a committee reviewing complaints against allopathic physicians. In addition, changing committee members frequently is more difficult to manage. Mr. Terranova suggested three committees – two complaint/investigation committees and a hearing committee. The complaint/investigation committees could each be comprised of four members – one allopathic physician, one osteopathic physician, one physician associate and one public member. That would leave nine members to choose from to assemble a hearing committee. If the quorum for the hearing committee is five, that would allow the Board to still hold a hearing if any of the nine members were unavailable or recused from the matter. Mr. Terranova also suggested adding an additional public member to the Board might be fair to increase representation of the public perspective.

Dr. Fay-LeBlanc suggested that it might be a good idea to make the complaint/investigation committees larger and then choose members from the committee that did not review the complaint for a hearing panel.

The workgroup discussed whether committee assignments should change after a period of time. Once a year was suggested.

The workgroup discussed the review of licensing matters that need to appear before the boards and it was recommended that the complaint/investigation committee(s) also review any licensing issues.

Mr. Michaud suggested adding definitions for allopathic and osteopathic to the draft document as well as possibly sharing the document with the Federation of State Medical Boards legal team for feedback. Dr. Vinsel asked if the workgroup can obtain information regarding what the required budget would be to increase staffing at BOL and what the increase in fees would need to be to sustain the budget. He considers this information important to make an informed decision regarding the feasibility of combining the Boards versus maintaining separate Boards. Other BOL members agreed. Mr. Terranova noted that Mr. Smith and Ms. MacArthur are currently working on obtaining this information and hope to have it available for the August meeting.

Public Comment

Jane Carreiro, DO, Dean of the College of Osteopathic Medicine at UNE: Dr. Carreiro questioned if it makes sense to keep separate Boards and increase members and staff to help with workloads. Mr. Terranova noted that an analysis is currently in process and the workgroup anticipates having information available for the August meeting.

Kathryn Brandt, DO, President of the Maine Osteopathic Association: Dr. Brandt commended the workgroup members for their work on this process. She commented that she would be very interested to see a comparison of the costs to maintain separate Boards versus combining Boards.

Robert Piccinini, DO, President of the American Osteopathic Association: He indicated that the AOA represents 200,000 osteopathic physicians and students. The AOA is opposed to the merger of the Boards as it will not be a benefit to patients or taxpayers in Maine.

Rich Thacker, DO, President Elect of the American Osteopathic Association: Dr. Thacker commented that the osteopathic profession is growing exponentially with one quarter of medical students in osteopathic programs. Dr. Thacker noted that two Boards are nimbler and more efficient than one large

Board and that osteopathic physicians and the public are better served by having a focused Board.

Amanda Mahan, Executive Director of the Maine Osteopathic Association: Ms. Mahan noted that she appreciates the opportunity to provide comments and requested that documents the workgroup reviews be provided to the public prior to workgroup meetings to allow time for review and preparation of relevant comments.

Jodie Hermann, DO: Dr. Hermann commented that she would like to see a comparison of the feasibility of combining the Boards versus remaining separate.

Workgroup members discussed providing documents the workgroup will review prior to meetings to allow the public time to review and prepare comments. Mr. Michaud noted that the workgroup might receive more comments and valuable feedback if more time is allowed for the public to review material. Dr. Fay-LeBlanc suggested that meeting material be provided to workgroup members in advance with a deadline to notify Mr. Terranova and Ms. MacArthur if they had any concerns about the information being provided in advance of the meeting. Workgroup members agreed to that plan.

Next Steps

Mr. Smith and Ms. MacArthur will work on a comparison of the feasibility of combining the Boards versus remaining separate for review at the August meeting.

Documents will be posted with the meeting agenda and available to the public approximately one week prior to the workgroup meeting.

The next meeting is August 27th at 5:30 p.m.

Adjourn 6:59

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 Act."

§XXXX Purpose

The Maine Board of Medicine is the state regulatory agency charged with protecting the public through the licensing and regulation of physicians and physician assistants in Maine.

§XXXX. Definitions

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

1. Board. "Board" means the Maine Board of Medicine established in Title 5, section 12004-A, subsection X.

2. Commissioner. "Commissioner" means the Commissioner of Professional and Financial Regulation.

3. 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.

4. Physician. "Physician" means an allopathic or osteopathic physician licensed by the Board.

5. Physician Assistant. "Physician Assistant" means a physician assistant licensed by the Board.

6. 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, 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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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.

§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. License required

1. Unlicensed practice. 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.

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.

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, its sole purpose being to protect the public health and welfare. The board carries out this purpose by ensuring that the public is served by competent and honest practitioners and by establishing minimum standards of proficiency in the

professions regulated by the board by testing, licensing, regulating and disciplining practitioners of those regulated professions.

§XXXX. Board membership

1. Membership; terms; removal. The board consists of 17 members appointed by the Governor as follows:

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

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

C. Four physician assistants. Each physician assistant must hold a valid license under this chapter and must have been in the actual practice of medicine in this State for a continuous period of five (5) years immediately preceding appointment.

D. Three 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 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, rule making, 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. Adjudicatory hearing panels shall to the extent possible be composed of three members of the same license type as the respondent licensee and at least one public member.

4. Meetings. The board shall hold regular monthly meetings and any additional special meetings at a time and place the chair may designate.

5. Board Officers. The board shall elect the following officers, whose duties shall be enumerated by rule, to serve two-year terms: chair; vice-Chair, secretary. The secretary of the board shall perform such duties as delegated by the board, including but not limited to license application review functions.

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;

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;

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 mandated reports 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 as tabulated and categorized by the annual statistical summary of the Physician Data Base of the Federation of State Medical Boards of the United States, Inc.

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. Financial 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 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.

Notwithstanding any other provision of this subsection, if the board contracts with the Commissioner of Education to provide funds for the costs of positions for which the State has contracted at the University of Vermont College of Medicine, or the Tufts University School of Medicine, the terms of the contract between the board and the commissioner must be in accordance with the requirements of Title 20-A, chapter 421;

14. 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;

15. 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;

16. 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;

17. 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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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;

18. 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;

19. 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;

20. Authority to order a mental or physical examination. 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. Failure to comply with a direction of the committee to submit to a mental or physical examination results in the immediate suspension of the license of the individual until the individual submits to the examination.

21. 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.

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.

SUBCHAPTER 3

LICENSURE

§XXXX. Application; fees; general requirements

1. Application. An applicant seeking a license from the board must submit an application with the 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 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 assistant licensed by the board who accepts the privilege of providing 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.

Failure to comply with a direction of the board or committee to submit to a mental or physical examination results in the immediate suspension of the license of the individual until the individual submits to the examination or if the individual is an applicant for licensure the denial of licensure.

Pursuant to Title 4, section 184, subsection 6, the District Court shall immediately suspend the license of a physician or physician assistant 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 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 assistant 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 assistants

1. Qualification for licensure. The board may issue to an individual a license to practice as a physician assistant under the following conditions:

- A. A license may be issued to an individual who:
 - (1) Graduated from a physician assistant program approved by the board;

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

- (2) Passed a physician assistant national certifying examination administered by the National Commission on Certification of Physician Assistants or its successor organization;
- (3) Demonstrates current clinical competency;
- (4) Does not have a license or certificate of registration 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 \$300; 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 assistants. 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 assistant;
- C. Requirements for collaborative agreements and practice agreements, including uniform standards and forms;
- D. Requirements for a physician assistant to notify the board regarding certain circumstances, including but not limited to any change in address, the permanent departure of the physician assistant from the State, any criminal convictions of the physician assistant and any discipline by other jurisdictions of the physician assistant;
- E. Issuance of temporary physician assistant licenses;
- F. Appointment of an advisory committee for continuing review of the physician assistant rules. The physician assistant members of the board must be members of the advisory committee;
- G. Continuing education requirements as a precondition to continued licensure or licensure renewal;
- H. Fees for the application for an initial physician assistant license, which may not exceed \$300; and
- I. Fees for the biennial renewal of a physician assistant license in an amount not to exceed \$250.

§XXXX-B. Physician assistant 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 assistant 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 from which the licensee is applying. 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 2A.

§XXXX. Full licensure of 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;

B. Graduate from an unaccredited medical school, be evaluated by the Educational Commission for Foreign Medical Graduates and receive a permanent certificate from the Educational Commission for Foreign Graduates; or

C. Graduate from an unaccredited medical school and achieve a passing score on the Visa Qualifying Examination or another comprehensive examination determined by the board to be substantially equivalent to the Visa Qualifying Examination.

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.

3. 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.

4. 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.

5. Fees. Each applicant shall pay a fee up to \$600 plus the cost of the qualifying examination or examinations.

6. 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.

7. 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 must be paid 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.

8. 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.

§XXXX. Full licensure of 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. 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.

4. Fees. An applicant must pay a fee up to \$600 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.

5. 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.

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

§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. 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. 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. 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. The fee for this license may be not more than \$300.

6. 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.

7. Contract students. An applicant who is qualified under section XXXX who received a medical education as a contract student as provided in Title 20-A, chapter 421, and who agrees to practice in a primary care or other specialized area as defined in Title 20-A, section 11803, subsection 2, or an underserved area as defined in Title 20-A, section 11802, is considered to have completed the postgraduate training requirements of section XXXX, subsection XXXX, upon satisfactory completion of at least 12 months in a graduate educational program approved as specified in section XXXX. The board may make the relicensure of an individual for 4 years after the individual's licensure under this subsection contingent on the individual's continuing to practice in an underserved area. This subsection applies only to individuals entering into a contract under Title 20-A, chapter 421, on or before December 31, 1984. The fee for this license may be not more than \$300.

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

1. Renewal of full licenses. A physician or physician assistant with a full license issued by the board 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 full license renewal that is valid for no longer than 2 years.

A. Beginning with licenses expiring after July 1, 1994, regardless of the date of initial licensure or last license renewal, the license of every physician and physician assistant born in an odd-numbered year expires at midnight in 1995 on the last day of the month of the individual's birth. The license of every physician and physician assistant born in an even-numbered year expires at midnight in 1996 on the last day of the month of the individual's birth. Upon expiration, a physician or physician assistant must renew the license issued pursuant to this section and this license must be renewed every 2 years by the last day of the month of birth of the individual seeking license renewal 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 full 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 full license may be reinstated within 90 days after the date of expiration upon 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 full license, the license immediately and automatically lapses. The board may reinstate a full license that has lapsed pursuant to subsection 4.

2. Criteria for full 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 full license with the intent of conducting active medical practice 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 practice of medicine in this State in any degree, including advising or prescribing medication for self, friends or family with or without charge, 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 \$500 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 full 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 full 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 full 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 practice of medicine continuously for at least the past 12 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 competency by passage of written examinations or practical demonstrations as the board may from time to time prescribe for this purpose through rulemaking.

§XXXX. Withdrawal of license

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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.

§XXXX. Inactive license status

A licensee who wants to retain licensure while not practicing may apply for an inactive status license. During inactive status, the licensee must renew the license and pay the renewal fee set by rule

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 composition of investigative committees are subject to the following. An investigation committee must contain, if possible:

A. If the investigation involves allegations against an allopathic physician: Two allopathic physicians, one osteopathic physician, one physician assistant, and one public member.

B. If the investigation involves allegations against an osteopathic physician: Two osteopathic physicians, one allopathic physician, one physician assistant, and one public member.

C. If the investigation involves allegations against a physician assistant: Three physician assistants, one physician, and one public member.

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. Failure to comply with a direction of the committee to submit to a mental or physical examination results in the immediate suspension of the license of the individual until the individual submits to the examination.

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. Consent agreements may be entered into only with the consent of the applicant or licensee, the 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 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.

3. Adjudicatory hearings. 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.

§XXXX. Complaints; reports; investigations

1. 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. 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 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 by an individual who is not licensed under this chapter 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:
 - (1) 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
 - (2) 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 that has been established in the practice for which the licensee is licensed or authorized by the board;
- 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 narcotic or hypnotic or other drugs listed as controlled substances by the Drug Enforcement Administration for other than accepted therapeutic purposes;
- K. Failure to report to the board a physician licensed under this chapter for addiction to alcohol or drugs or for mental illness in accordance with Title 24, section 2505, except when the impaired physician is or has been a patient of the licensee or the physician has been referred to the Medical Professionals Health Program;
- 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 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. 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;
- O. Noncompliance with an order of or consent agreement executed by the board;
- P. 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;
- Q. Failure to timely respond to a complaint notification sent by the board;
- R. Failure to comply with the requirements of Title 22, section 7253;
- S. Advertising, offering or administering conversion therapy to a minor.

2. Judicial review. Notwithstanding any provision of Title 10, section 8003, subsection 5-A to the contrary, any nonconsensual revocation pursuant to Title 10, section 8003, subsection 5-A 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-A, 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 assistants

A physician or physician assistant may delegate to the physician's or physician assistant'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 assistant; the activities being delegated do not, unless otherwise provided by law, require a license, registration or certification to perform; the physician or physician assistant 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 assistant ensures that the employees or support staff perform these delegated activities competently and safely. The physician or physician assistant 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 assistant's agent. This section may not be construed to apply to registered nurses acting pursuant to Chapter 31 or physician assistant acting pursuant to this chapter.

§XXXX Physician assistants; scope of practice and agreement requirements

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Collaborative agreement" means a document agreed to by a physician assistant 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.

B. "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.

C. "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.

D. "Physician" means a person licensed by the board.

E. "Physician assistant" means a person licensed by the board. .

F. "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.

G. "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 under the federal Controlled Substances Act, 21 United States Code, Section 812.

2. Scope of practice. A physician assistant may provide any medical service for which the physician assistant has been prepared by education, training and experience and is competent to perform. The scope of practice of a physician assistant 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.

3. Dispensing drugs. Except for distributing a professional sample of a prescription or legend drug, a physician assistant 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.

4. Consultation. A physician assistant shall, as indicated by a patient's condition, the education, competencies and experience of the physician assistant 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 assistant 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.

5. Collaborative agreement requirements. A physician assistant 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 assistant's scope of practice, except that a physician assistant 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 assistant is legally responsible and assumes legal liability for any medical service provided by the physician assistant in accordance with the physician assistant'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 assistant 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 assistant is no longer subject to the requirements of this subsection.

6. Practice agreement requirements. A physician assistant 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 assistant has a practice agreement with an active physician, and other health care professionals as necessary, that describes the physician assistant's scope of practice. A physician assistant is legally responsible and assumes legal liability for any medical service provided by the physician assistant in accordance with the physician assistant's scope of practice under subsection 2 and a practice agreement under this subsection. A physician assistant 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 assistant'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 assistant 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.

7. 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 assistants, this section must be liberally construed to authorize physician assistants 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 assistant 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 assistant'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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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

An allopathic physician licensed pursuant to chapter 48, an osteopathic physician licensed pursuant to chapter 36, 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 Commissioners of the Profession 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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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. On or after January 1, 2017, 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. On or after January 1, 2017, 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 as a condition of prescribing 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 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 assistants in Maine:

1. The Maine Board of Medicine is created and established by law. All references to, responsibilities of and authority conferred upon the 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 assistants 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.

Board of Licensure in Medicine - Board of Osteopathic Licensure
Workgroup
ZOOM meeting
August 27, 2025
5:30 p.m. – 7:01 p.m.

Board Members Present

Public Member Peter Michaud, JD, RN (BOL)
Melissa Michaud, PA (BOL)
Public Member Dennis Smith, Esq. (BOL)
Public Member Mary-Anne Ponti, RN, DBA (BOL)
John Brewer, DO (BOL)
Paul Vinsel, DO (BOL)
Lisa Ryan, DO (BOL)
Renée Fay-LeBlanc, MD (BOLIM)
Public Member Lynne Weinstein (BOLIM) – excused at 6:11 p.m.

Board Staff Present

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

Legal Counsel Present

Assistant Attorney General Jennifer Willis (BOLIM)
Assistant Attorney General Lisa Wilson (BOL)

A roll call of board members present was conducted.

Kentucky Board Law

The workgroup reviewed Kentucky law regarding the use of committees to review complaints and conduct hearings. The Kentucky Board President divides members into two seven member panels, with each panel having at least one public member. The President of the Board is not a permanent member of either panel but may cast the deciding vote in the event of a tie or serve on a panel to meet quorum. Panels meet on alternating months, so each panel meets 6 times per year. The full Board meets quarterly. The panels have the authority to render final decisions.

The workgroup liked the process used by Kentucky and should incorporate a similar process into statute if the Boards decide to merge.

Draft Budget Information

The workgroup reviewed draft budget information. The draft included three scenarios:

- Scenario A based on the BOL remaining separate and adding four additional staff members. This scenario would result in an increase in renewal fees of \$438 per licensee every two years.

- Scenario B based on the BOLIM remaining separate and adding four additional staff members. This scenario would result in an increase in renewal fees of \$88 per licensee every two years.
- Scenario C based on merger of the BOL and BOLIM and adding four additional staff members. This scenario would result in an increase in renewal fees of \$74 per licensee every two years.

Workgroup members questioned whether additional staff would be required if the Boards merged. Mr. Terranova indicated that if the Boards merged, all current staff would remain. In addition, BOLIM currently has an unfilled position that could be utilized if additional staff were needed.

The workgroup also discussed the BOLIM Medical Director position and the potential 25% increase in workload and asked how many hours per week the Medical Director works. Mr. Terranova responded that the Medical Director is a full-time position and reviews records, bookmarks records for Board review and assists with policy development. The increase in workload would have to be reviewed in the event the Boards merge.

Mr. Smith noted that the draft budget was based on a part-time Medical Director working 30 hours per week, an investigative secretary to handle complaints and two licensing specialists.

Draft Proposed Statute with Changes and Comments

Mr. Terranova noted that the composition for hearing panels will need to be determined. The workgroup has discussed this issue but has not made a definitive decision. In addition, Mr. Terranova noted that the proposed statute indicates that the Board will hold regular monthly meetings. The language may be too restrictive. Current BOLIM statute indicates the Board will meet at least three times per year. Workgroup members agreed that less restrictive language is appropriate.

In reviewing the section regarding Board Officers, Mr. Terranova noted a difference in the current structure of BOLIM and BOL. BOLIM has a Chair and a Secretary. BOL has a Chair, Vice Chair and Secretary. If the Boards merge, the workgroup will need to decide on Board Officers.

Mr. Michaud also noted that the proposed statute assigns license application review to the Secretary. Mr. Terranova noted that BOLIM staff can approve license applications with no negative or questionable information. If there are issues, the application is referred to the Secretary who can approve the application or refer it to the full Board. AAG Willis clarified that BOLIM's statute allows delegation to the Secretary and BOLIM delegates by rule.

Mr. Terranova recommended a change regarding the annual report to the Legislature. Currently BOLIM must include a statistical summary from FSMB. However, the FSMB tabulates disciplinary actions differently than BOLIM. BOLIM includes an explanation each year of the discrepancy in disciplinary actions. Workgroup members felt the Legislature is interested in the Boards statistics and agreed this provision could be removed.

Mr. Terranova also pointed out a provision for Contracting with Commissioner of Education and questioned if this was currently needed. Legal counsel will review and report back.

AAG Wilson commented that the section regarding ordering physical and mental examinations is an improvement over BOL's current statute.

Mr. Terranova discussed the current provision under physician associate licensing regarding an advisory committee. He noted that the Advisory Committee has not met since the statute was updated in 2016.

He asked the workgroup if they felt this Advisory Committee was necessary or if PA representation on the Board is sufficient. Ms. Michaud felt that PA representation on the Board is sufficient and was not sure what additional role the Advisory Committee might serve. Workgroup members agreed this provision is no longer needed.

Mr. Terranova noted under the licensure of allopathic physician section that Canadian graduates were accredited by the US until June of this year. Canadian graduates are now considered foreign medical graduates. He suggested adding acceptance of Canadian graduates to the statute. There was also discussion about the terminology moving to international medical graduate (IMG) and the subgroup internationally trained physician (ITP). IMGs are physicians who have graduated from a foreign medical school and ITPs are physicians who have graduated from a foreign medical school and have completed post graduate training and/or worked in a foreign country according to its regulations.

Mr. Terranova pointed out that BOLIM has the authority to create special license categories for allopathic physicians, such as administrative and emeritus licenses, but cannot create those for PAs because the BOL does not have that authority. He recommended adding that authority to the proposed statute for all licenses.

The workgroup reviewed twelve pages of the draft and then determined that it would stop at this point to allow time for public comment. Mr. Terranova reminded workgroup members that if they have questions or comments between meetings, they can submit those to staff.

Public Comment

Mr. Terranova noted that one written comment was received from a UNE student and was provided to the workgroup in the meeting material.

Kathryn Brandt, DO – Dr. Brandt thanked workgroup members for their continued work. She commented that the draft budgets appeared to be estimating universal changes across three different scenarios. She feels it would be more pertinent to look at scenarios of what an appropriate BOL would look like and not give resources where they are not needed.

Rich Thacker, DO – Dr. Thacker practices in Tallahassee, FL. He is in favor of keeping the Boards separate and indicated it is attractive to physicians, especially young physicians. Twenty-five percent of students are in DO programs. Separate Boards provide optimal service and unique understanding of osteopathic practice.

John Gimpel, DO – Dr. Gimpel was previously the Dean of the University of New England and now works at the National Board of Osteopathic Medical Examiners. Osteopathic physicians are part of a profession that self regulates. Dr. Gimpel indicated that some of the strongest states for osteopathic medicine have separate Boards. He also urged workgroup members to keep patients first and foremost in deliberations.

Teresa Hubka, DO – Dr. Hubka thanked the workgroup for allowing observation and comments. She supports separate licensing Boards. She noted that the osteopathic profession has a different educational process than allopathic physicians and it is important to maintain that distinct educational and licensing process. Dr. Hubka also noted that the profession is growing quickly.

John Diefenderfer, DO – Dr. Diefenderfer is a faculty member of the Maine Dartmouth Residency Program. Dr. Diefenderfer asked if the workgroup had gathered data from states that have separate boards and how they are able to maintain separate boards. He asked about the potential for restructuring

vs. merging.

Following public comments Ms. Ponti asked how the workgroup was doing from a time standpoint to have a report to the Legislature in January.

Mr. Terranova said that work should be concluded by November so that the Boards can review the final product in December.

Next Steps

Finish review of proposed statute at next meeting

The next meeting is on September 24th at 5:30 p.m.

Adjourn 7:01 p.m.

201 KAR 9:240. Emergency orders and hearings; appeals and other proceedings.

RELATES TO: KRS Chapter 13B, 218A.205, 311.565(1)(i), 311.591(3), 311.592, 311.593, 311.595, 311.852

STATUTORY AUTHORITY: KRS 311.565(1)(a), (i)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 311.565(1)(i) authorizes the board to promulgate administrative regulations to promote the efficient and fair conduct of disciplinary proceedings. This administrative regulation establishes the procedure to be followed in handling emergency proceedings in regard to any licensee before the board.

Section 1. Authority to Issue Emergency Order; Timing.

(1) An inquiry panel or the panel's chair, acting on behalf of the inquiry panel, may issue an emergency order restricting or suspending a licensee's license to practice within the Commonwealth of Kentucky in accordance with KRS 311.592 and 13B.125.

(2) An inquiry panel shall make this determination following a completed investigation pursuant to KRS 311.591(3) at a regularly scheduled meeting of the inquiry panel.

(3)

(a) An inquiry panel's chair may act on behalf of the inquiry panel and issue an emergency order restricting or suspending a licensee's license to practice within the Commonwealth of Kentucky if the panel chair determines that a basis for an emergency order as established in subsection (1) of this section exists and the circumstances of the specific case warrant emergency action prior to the next regularly scheduled meeting of the inquiry panel.

(b) If an emergency hearing is scheduled prior to the next regularly scheduled meeting of the inquiry panel, the panel chair may act on behalf of the inquiry panel and issue the complaint required to support the continuation of the emergency order.

(c) If the panel chair acts on behalf of the inquiry panel pursuant to paragraph (a) or (b) of this subsection, the panel chair shall report any action to the inquiry panel at its next regularly scheduled meeting.

Section 2. Findings of Fact and Conclusions of Law.

(1) The inquiry panel, or the panel chair acting on the panel's behalf, may consider any evidence or information in making a charging decision pursuant to KRS 311.591(3) or in making the determination to issue an emergency order pursuant to Section 1 of this administrative regulation. The evidence or information may include:

(a) An application for licensing or renewal filed by the licensee with any licensing board;

(b) Any prior or current order issued by the board or one (1) of its panels affecting the licensee's Kentucky license;

(c) Any prior or current order issued by another state's licensing authority affecting the licensee's license in that state;

(d) The records of any criminal proceeding involving the licensee;

(e) A report by or record of any governmental agency, including a law enforcement agency report, a Kentucky All Schedule Prescription Electronic Reporting (KASPER) report or summary, or a reference to a governmental agency or KASPER report;

(f) Patient records maintained by the licensee, or summaries of or references to the contents of those records;

(g) Records or reports issued or maintained by a pharmacy;

(h) Records or reports issued or maintained by a hospital, including a peer review report relating to the licensee or medical records of a patient treated by the licensee in the hospital;

(i) Records or reports issued or maintained by any business;

- (j) An investigative report prepared by a board investigator, including any summary of a verbal or written statement by a witness or an evidentiary document reviewed by an investigator;
 - (k) An investigative report prepared by a board investigator involving another investigation conducted by the board relating to the licensee;
 - (l) An oral or written statement by the licensee, or the licensee's agent, relating to the investigation;
 - (m) A report of a clinical skills assessment relating to the licensee, including a report by a board-approved assessor, including the Center for Personalized Education for Physicians (CPEP) or LifeGuard;
 - (n) A physical, mental, or substance abuse evaluation or assessment of the licensee;
 - (o) A written report of a patient record review conducted by a consultant under contract with the board to perform reviews; or
 - (p) A written report of a patient record review conducted by a licensed professional performing a review on behalf of the licensee.
- (2) The evidence or information considered by the inquiry panel or panel chair, acting on behalf of the inquiry panel, shall constitute the board's record of proceedings relating to the issuance of an emergency order of restriction or suspension.
- (3) If the inquiry panel or the panel chair, acting on behalf of the inquiry panel, issues an emergency order of restriction or suspension against a licensee's license, the emergency order shall be a written order and shall include findings of fact and conclusions of law, supported by the board's record of proceedings, upon which the agency bases the emergency order.
- (4) Any emergency order shall be served upon the affected licensee in the manner specified in KRS 13B.050(2). The emergency order shall become effective immediately upon receipt by the affected licensee or the licensee's representative.

Section 3. Authority to Issue Emergency Order of Suspension Upon Felony Indictment.

- (1) If a licensee is indicted in any state for a crime classified as a felony in that state and the conduct charged relates to a controlled substance, that licensee's practice shall be considered an immediate danger to the public health, safety, or welfare pursuant to KRS 311.592, 311.852, and 13B.125.
- (2) If the board receives verifiable information that a licensee has been indicted in any state for a crime classified as a felony in the state of indictment and the conduct charged relates to a controlled substance, the inquiry panel or panel chair, acting on behalf of the inquiry panel, shall immediately issue an emergency order suspending or restricting that licensee's Kentucky license to prohibit the licensee from prescribing, dispensing, administering, or otherwise utilizing a controlled substance in Kentucky, until further order following the final resolution of the criminal charges in the indictment.
- (3) The emergency order of suspension shall remain in effect until:
- (a) The criminal charges contained in the indictment are finally resolved; and
 - (b) The board's hearing panel has finally resolved the matter after receipt of the court documents finally resolving the criminal charges in the indictment.

Section 4. Request for and Timing of Emergency Hearing; Waiver.

- (1) A licensee required to comply with an emergency order may request an emergency hearing at any time between the effective date of the emergency order and the effective date of an order finally resolving the underlying complaint.
- (2)
- (a) A request for an emergency hearing shall be presented to the board in writing, but may be submitted by facsimile or email.
 - (b) Upon receipt of a written request for an emergency hearing, the board shall schedule the emergency hearing on one (1) of the ten (10) working days following the

date of receipt of the written request. The day on which the written request is received by the board shall not be considered one (1) of the ten (10) working days.

(c) A written request shall be considered received on a particular work day if it is received by the board during the board's scheduled operating hours for that day. If the board receives a request for an emergency hearing by facsimile or email received after scheduled operating hours, the request shall be considered to have been received the next scheduled work day of the board.

(3)

(a) A written request for an emergency hearing shall be considered a certification by the affected licensee and the licensee's counsel, if any, that the licensee is available to participate in an emergency hearing on any of the ten (10) working days following the date of the board's receipt of the written request for an emergency hearing.

(b) The refusal of the licensee to accept a hearing date on a date specified by the board within the ten (10) working days shall constitute a waiver of the requirement of KRS 13B.125(3) to conduct the emergency hearing within ten (10) working days of receipt of a request.

(c) If there is a waiver of the ten (10) working day requirement, the hearing officer and parties shall schedule the emergency hearing to commence at the next date available to the hearing officer and both parties.

(4)

(a) Unless there is a waiver of the requirement, the board shall commence the emergency hearing within ten (10) working days of receipt of the written request for an emergency hearing.

(b) If the parties are unable to conclude the emergency hearing on the initial date assigned, the emergency hearing shall resume on the next date available to the hearing officer and both parties and shall continue on dates available to the hearing officer and both parties until concluded.

Section 5. Scope and Conduct of Emergency Hearing; Hearing Officer's Role.

(1) The emergency hearing shall be conducted by the inquiry panel, its panel chair, acting on behalf of the inquiry panel, or by a qualified hearing officer appointed by the board's executive director.

(2) The singular function of the party conducting the emergency hearing shall be to determine whether the findings of fact providing the bases for the emergency order are supported by substantial evidence and, if so, constitute one (1) or more violations of KRS 311.595.

(3) Given the ten (10) working day requirement of KRS 13B.125(3) and the unique nature of the hearing, it shall not be practicable pursuant to:

(a) KRS 13B.125(3) to conduct the emergency hearing in conformity with the provisions of KRS 13B.050;

(b) KRS 13B.060;

(c) KRS 13B.070;

(d) KRS 13B.080(2);

(e) KRS 13B.080(3){as it relates to discovery orders} or (4){to the extent it conflicts with this administrative regulation};

(f) KRS 13B.090(1){to the extent it prohibits consideration of hearsay evidence}, (2){other than the requirement that all testimony shall be made under oath or affirmation}, (3), or (7);

(g) KRS 13B.110; or

(h) KRS 13B.120.

(4) There shall not be a motion practice, prior to or as part of the emergency hearing, relating to the legality or validity of the emergency order under consideration or relating

to evidentiary issues.

(5)

(a) The standards of acceptable and prevailing practice within the Commonwealth may be determined by an expert review of a licensee's patient records by a qualified expert.

(b) An expert review may be conducted on the board's behalf by a licensed professional who has entered into a contractual relationship with the board to serve as a board consultant. The contractual relationship shall indicate that the board has determined that the professional is legally qualified to provide an expert opinion regarding the standards of acceptable and prevailing practice within the Commonwealth of Kentucky and whether the affected licensee has violated those standards or committed other professional violations of the board's statutes.

(c) The party conducting the emergency hearing shall not conduct a separate hearing or inquiry into the qualifications of the contractual reviewer who performed the record review on behalf of the board or of a licensed professional who performed a record review on behalf of the affected licensee.

(6) The emergency hearing shall be conducted as required by KRS Chapter 13B and this subsection.

(a) The board shall produce and the hearing officer shall accept the record of the proceedings relating to the issuance of an emergency order under consideration.

(b)

1. The board shall not be required to produce any further evidence to support the emergency order.

2. The board may call the affected licensee to testify, as if under cross-examination, regarding the factual accuracy of evidence or information cited in the record of proceedings relating to the issuance of the emergency order.

(c) The affected licensee may testify, produce factual evidence, produce hearsay evidence through documents, or call lay witnesses to the extent that the evidence specifically tends to demonstrate that a factual statement relied upon by the board's contractual reviewer or by the inquiry panel or panel chair, acting on behalf of the inquiry panel, is factually incorrect or false.

(d) The affected licensee may only call the board's contractual reviewer for the purpose of cross-examination if the hearing officer determines on the record that the licensee's evidence has established that one (1) or more factual statements relied upon by the contractual reviewer in the expert report is demonstrably false or incorrect. If the hearing officer makes that determination, the affected party may call the board's contractual reviewer for the purpose of cross-examination under the following conditions:

1. The cross-examination of the board's contractual reviewer is scheduled at the earliest date available to the reviewer and the parties that does not disrupt the normal operation of the reviewer's professional practice and does not disrupt the care of the reviewer's normal patients;

2. The cross-examination of the board's contractual reviewer is limited to factual statements and opinions rendered in the reviewer's report, and the effect upon an opinion of a determination that one (1) or more underlying factual statements relied upon by the reviewer is false or factually incorrect; and

3. Upon completion of the cross-examination, the board and the hearing officer may ask questions of the contractual reviewer relevant to the cross-examination.

(7)

(a) Within five (5) working days of completion of the emergency hearing, the hearing officer shall issue a written decision in which the hearing officer shall:

1. Affirm the emergency order if there is substantial evidence of a violation of law and the inquiry panel has determined that a violation constitutes an immediate

danger to the public health, safety, or welfare. If there is substantial evidence of a violation of law, the hearing officer shall not substitute his or her judgment as to the level of public protection necessary for the emergency order;

2. Revoke the emergency order if there is no substantial evidence of a violation of law. The findings of fact shall be found to be supported by substantial evidence if there is a factual basis for the findings, even if there is a conflict in the evidence or information considered by the inquiry panel or panel chair, acting on behalf of the inquiry panel. A finding that there is no substantial evidence to support the findings of fact shall require a finding that there is a complete absence of factual basis for the findings; or

3. Modify the emergency order if the emergency order relied upon multiple violations of law and the hearing officer has determined that there is no substantial evidence to support one (1) or more of those violations. Upon making that finding, the hearing officer may consider each remaining violation for which there is substantial evidence and may modify the level of protection if the modified protection fully protects the public health, safety, or welfare based upon the dangers presented by the licensee's commission of each remaining violation.

(b) The hearing officer shall not include additional findings of fact or conclusions of law in any written decision affirming the emergency order under consideration. The written decision shall be sufficient if it determines that there was substantial evidence of a violation of law and the panel had determined that the violation constituted an immediate danger to the public health, safety, or welfare.

(c) If the hearing officer issues a written decision revoking or modifying the emergency order under consideration, the hearing officer shall include findings of fact and conclusions of law to support the action.

Section 6. Judicial Review. Judicial review of a final order resulting from an emergency hearing shall comply with KRS 13B.140, 13B.150, 13B.160, and 311.593.

(39 Ky.R. 664; Am. 1662; eff. 3-4-2013; 42 Ky.R. 2804; 43 Ky.R. 15; eff. 7-20-2016; 47 Ky.R. 371; eff. 11-19-2020.)

311.591 Inquiry and hearing panels -- Grievances -- Review by inquiry panel -- Complaints -- Hearing by hearing panel -- Final order -- Discipline -- Release of information -- Privacy.

- (1) The president of the board shall divide the membership of the board, excluding himself, into two (2) panels of seven (7) members, each panel to include at least one (1) consumer member. Each panel shall have the power to act as an inquiry or a hearing panel. The president shall not be a permanent member of either panel, but shall have the power to render the deciding vote whenever a tie vote is rendered by either panel and shall have the power to serve as a member of either panel when necessary to achieve a quorum by majority.
- (2) Grievances may be submitted by an individual (including board members), organization, or entity. Each grievance shall be investigated as necessary and the executive director shall assign each grievance to an inquiry panel. All inquiry panels and the executive director shall have the power to issue investigatory subpoenas for the appearance of any person or production of any record, document, or other item within the jurisdiction of the Commonwealth. The panel or executive director may seek enforcement of investigatory subpoenas and search warrants in the courts of the Commonwealth as may be necessary.
- (3) Upon completion of its inquiry, the inquiry panel shall make a finding that:
 - (a) There is no evidence of a violation of any medical practice act and no further action is necessary;
 - (b) There is insufficient evidence of a violation to warrant the issuance of a complaint, but that there is evidence of a practice or activity that requires modification and the panel may issue a letter of concern under KRS 311.550(22). The letter of concern shall be a public document and may be used in future disciplinary actions against the physician;
 - (c) The grievance discloses an instance of misconduct which does not warrant the issuance of a complaint; in these instances, the panel may admonish the physician for his misconduct; or
 - (d) The grievance discloses one (1) or more violations of the provisions of this chapter which warrant the issuance of a complaint; in these instances, the panel shall cause a complaint to be prepared, signed by the presiding officer, which shall contain sufficient information to apprise the named physician of the general nature of the charges.
- (4) The inquiry panel shall cause a complaint to be served on the charged physician by personal delivery or by certified mail to the physician's last address of which the board has record. The physician shall submit a response within thirty (30) days after service. Failure to submit a timely response or willful avoidance of service may be taken by the board as an admission of the charges.
- (5) Upon the issuance of the complaint, the executive director shall assign the matter for an administrative hearing by a hearing panel. No member who served on the inquiry panel may also serve as a member of the hearing panel. The hearing panel or the hearing officer on behalf of the panel shall preside over all proceedings pursuant

to the issuance of a complaint.

- (6) The board may promulgate administrative regulations regarding the informal disposition of any complaint, and an informal disposition may be made at any stage of the proceeding.
- (7) Upon completion of an administrative hearing, the hearing panel shall issue a final order that:
 - (a) Dismisses the complaint upon a conclusion that the provisions of this chapter have not been violated;
 - (b) Finds a violation of the provisions of this chapter, but does not impose discipline because the panel does not believe discipline to be necessary under the circumstances; or
 - (c) Imposes discipline upon the licensee; in these instances, the panel may revoke, suspend, restrict, deny, or limit a license, or may reprimand a licensee or place a licensee on probation under terms the panel may establish to protect the licensee, his patients, or the general public. The hearing panel may impose a fine whenever it finds that a violation of this chapter has occurred. If the board substantiates that sexual contact occurred between the physician and the patient while the patient was under the care of or in a professional relationship with the physician, the physician's license may be revoked or suspended with mandatory treatment of the physician as prescribed by the board. The board may require the physician to pay a specified amount for mental health services for the patient which are needed as a result of the sexual contact. The hearing panel's order shall be considered the final order of the board regarding the matter.
- (8) Regardless of the restrictions on public disclosure of information established in subsection (9) of this section, the board may order information derived from any investigation or inquiry be released to the physician licensure authority of another state or to any health care or mental health care facility licensed and regulated by the Commonwealth of Kentucky upon a showing that the information is necessary to determine the propriety of a physician practicing in a particular state or facility.
- (9) The presiding officer at any proceeding held pursuant to a complaint or show cause order shall take whatever measures are necessary to protect the privacy interests of individuals other than the charged physician upon a showing that evidence is to be introduced, the public disclosure of which would constitute a clear invasion of personal privacy. It is the general policy of the Commonwealth that administrative proceedings should be open to the public. Therefore, in applying this subsection, the presiding officer shall balance the competing interests and employ the least restrictive measures available to protect the privacy interests involved.

Effective: July 15, 2002

History: Amended 2002 Ky. Acts ch. 130, sec. 13, effective July 15, 2002. -- Amended 1996 Ky. Acts ch. 318, sec. 255, effective July 15, 1996. -- Amended 1994 Ky. Acts ch. 190, sec. 6, effective July 15, 1994; ch. 265, sec. 4, effective July 15, 1994; and ch. 470, sec. 4, effective July 15, 1994. -- Amended 1986 Ky. Acts ch. 302, sec. 8, effective July 15, 1986. -- Created 1984 Ky. Acts ch. 251, sec. 4, effective July 13,

1984.

Legislative Research Commission Note (7/15/94). This statute was amended by 1994 Ky. Acts chs. 265 and 470, which were companion bills and are substantively identical. These Acts have been codified together. For the few minor variations between the Acts, Acts ch. 470 prevails under KRS 446.250, as the Act which passed the General Assembly last. 1994 Ky. Acts ch. 190, sec. 6 is not in conflict with these two Acts and has been codified together with them.

From: Javier-Wong, Philip <Philip.Javier-Wong@maine.gov>

Sent: Monday, August 25, 2025 2:10 PM

To: [REDACTED]; MacArthur, Rachel <Rachel.MacArthur@maine.gov>

Cc: Hendsbee, Rachel H <Rachel.H.Hendsbee@maine.gov>; Terranova, Tim E <Tim.E.Terranova@maine.gov>

Subject: RE: FW: Hypothetical DO Board Budget?

Good afternoon Dennis,

Here are the costs for the additional space and the part-time medical director position along with the prior estimates for the 3 other new positions. The office space estimate is based on the current rent expense assuming that we'd need to keep the existing leased space, and that a comparable space would be needed for the additional staff. Where that space is available and for how much is a hypothetical, i.e. the quote for an actual available space may or may not be significantly higher. The medical director costs are based on an individual at Step 4 working 30 hours/week. I also included a \$10K placeholder for equipment without knowing if there was something more specific in mind.

The 3 scenarios below are the additional **annual** costs borne by each board separately in A and B, then combined in C (figures are rounded):

<u>Proposed Changes</u>	<u>Annual Expense</u>	<u>Scenario A</u>	<u>Scenario B</u>	<u>Scenario C</u>
		BOL- only, 1,951 licensees <u>Per License</u> <u>+/-</u>	BOLIM-only, 9,865 licensees <u>Per License</u> <u>+/-</u>	BOL + BOLIM, 11,816 licensees <u>Per License</u> <u>+/-</u>
Two (2) Licensing Specialists	196,000	\$100	\$20	\$17
One (1) Investigative Secretary	92,000	\$47	\$9	\$8
One (1) Medical Director, Part-time (30 hrs/week)	116,000	\$59	\$12	\$10
Additional office space	15,616	\$8	\$2	\$1
Additional equipment?	10,000	\$5	\$1	\$1
		\$219	\$44	\$37
<u>@ Renewal</u>		<u>\$438</u>	<u>\$88</u>	<u>\$74</u>

The licensee information is based on just renewals; the renewal amounts are for every two years. The figures above do not take into account that expenses are expected to increase annually.

Hope this helps with the decision-making.

Thank you.

— Philip

Licensure Fees and Requirements (Not including USMLE and NBOME examination fees)

SMB	Initial licensure application fee (base free not including add'l fees that may be charged)	Licensure renewal fee	Licensure renewal interval	Interstate Medical Licensure Compact Member	Initial licensure fee for a license using the IMLC	Licensure renewal fee for a license using the IMLC
AL	\$175 Initial application fee plus \$65 criminal background fee where applicable. / \$75 issuance fee to Med. Licensure Commission. These fees apply to MD/DO licenses. PA license fees differ.	\$300 (MD/DO) \$150 Controlled Substance Certificate (MD/DO) PA licenses and other certificates differ	1 year	Yes	75	300
AK	500	300	2 years	No		
AR	500	220	1 year; Multi-year (2) option available	No		
AZ-M	500	500	2 years	Yes	500	500
AZ-O	450	636	2 years	Yes	400	636
CA-M	1151	1151	2 years	No		
CA-O	\$425 Initial application fee plus \$200 application processing fee	400	2 years	No		
CO	390	changes each year	2 years	Yes	415	Changes each year
CT	565	575	1 year	Yes		
DE	378	378	2 years	Yes	425	
DC	803	803	2 years	Yes	803	803
FL-M	424	360	2 years	Yes		
FL-O	305	305	2 years	Yes		
GA	500	230	2 years	Yes	500	230
GU	400	250	2 years	Yes	400	250
HI	MD: Full biennium - \$392; 1/2 biennium \$221 DO: Full biennium - \$510; 1/2 biennium \$384	MD: \$402 on-time; \$408 late DO: \$312 on-time; \$392 late	2 years	Yes		
ID	400	200	2 years	Yes	370	200
IL	500	543	3 years	Yes	500	543
IN	250	200	2 years	Yes		
IA	450	450	2 years	Yes	450	450
KS	300	300	1 year	Yes	300	
KY	300	150	1 year	Yes	300	150
LA	382	330	1 year	Yes	382	
ME-M	\$600 plus \$100 exam fee	500	2 years	Yes	700	500
ME-O	350	525	2 years	Yes	350	
MD	\$790 - AMGs & \$890 - IMGs	486	2 years	Yes	790	486
MA	600	600	2 years	No		
MI-M	367.7	308.25	3 years	Yes	367.7	360.55
MI-O	367.7	308.25	3 years	Yes	367.7	360.55
MN	200	192	1 year	Yes	392	192
MS	550	300	1 year	Yes	600	300
MO	75	100	1 year	Yes		
MT	500	560	2 years	Yes	375	560
MP						
NE	350	171	2 years	Yes	125	171
NV-M	1425	750	2 years	Yes	375	750
NV-O	\$500 - DO; \$300 - PA	\$350- DO; \$150 - PA	1 year	Yes	500	350
NH	300	350	2 years	Yes	328	350
NJ	805	580	2 years	Yes		
NM	400	600/triennial ren	3 years	No		
NY	735	600	2 years	No		
NC	400	250	1 year	No		
ND	400	400	2 years	Yes	400	400
OH	305	305	2 years	Yes	308.5	
OK-M	500	200	1 year	Yes	500	
OK-O	575	\$225 (in-state); \$150 (out-of-state); \$200 (fully retired/resident)	1 year	Yes	575	225
OR	\$375 for MD/DO	\$243/year	2 years	No		
PA-M	35	360	2 years	Yes		
PA-O	45	220	2 years	Yes		
PR	500	250	3 years	No		
RI	1090	1090	2 years	Yes		
SC	580	155	2 years	No		
SD	400	400	2 years	Yes	400	400
TN-M	510	310	2 years	Yes	510	310
TN-O	410	310	2 years	Yes	410	310
TX	817	Initial Registration \$270-\$456	2 years	Yes	817	
UT	200	183	2 years	Yes	200	183
VT-M	650 for MD and DPM, 225 PA, 120 AA & RA, 75 for LTL	525 MD & DPM, 215 PA, 120 AA & RA, 75 LTL	2 years	Yes	650	525
VT-O	500	500	2 years	Yes	500	
VI	250	1000	2 years	No		
VA	302	270	2 years	No		
WA-M	491	956	2 years	Yes	491	986
WA-O	391	441	1 year	Yes	391	441
WV-M	400	400	2 years	Yes	400	400
WV-O	400	400	2 years	Yes	400	400
WI	60	60	2 years	Yes	60	60
WY	400	155	1 year	Yes	325	155

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 Act."

§XXXX Purpose

The Maine Board of Medicine is the state regulatory agency charged with protecting the public through the licensing and regulation of physicians and physician ~~assistant~~ associates in Maine.

§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.

1. **Board.** "Board" means the Maine Board of Medicine established in Title 5, section 12004-A, subsection X.

2. **Commissioner.** "Commissioner" means the Commissioner of Professional and Financial Regulation.

3. **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.

4. **Osteopathic Physician.** "Osteopathic Physician" means a physician who graduated from medical school with a DO degree.

4. **Physician.** "Physician" means an allopathic or osteopathic physician licensed by the Board.

5. **Physician ~~Assistant~~Associate.** "Physician ~~Assistant~~Associate" means a physician ~~assistant~~ associate licensed by the Board.

6. **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, 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;

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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.

I. The rendering of medical services by physician associates

§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. License required

1. Unlicensed practice. 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.

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.

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, its sole purpose being to protect the public health and welfare. The board carries out this purpose by ensuring that the public is served by competent and honest practitioners and by establishing minimum standards of proficiency in the professions regulated by the board by testing, licensing, regulating and disciplining practitioners of those regulated professions.

§XXXX. Board membership

1. Membership; terms; removal. The board consists of 17 members appointed by the Governor as follows:

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

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

C. Four physician ~~assistant~~associates. Each physician ~~assistant~~associate must hold a valid license under this chapter and must have been in the actual practice of medicine in this State for a continuous period of five (5) years immediately preceding appointment.

D. Three 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 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, rule making, 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. Adjudicatory hearing panels shall to the extent possible be composed of three members of the same license type as the respondent licensee and at least one public member.

4. Meetings. The board shall hold ~~regular monthly meetings~~a minimum of three regular meetings a year and any additional special meetings at a time and place the chair may designate.

Commented [TT1]: There was discussion about the size and composition panel but nothing definitive was determined.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

5. Board Officers. The board shall elect the following officers, whose duties shall be enumerated by rule, to serve two-year terms: chair; vice-Chair, secretary. The secretary of the board shall perform such duties as delegated by the board ~~through rule, including but not limited to license application review functions.~~

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;

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;

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 mandated reports 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 as tabulated and categorized by the annual statistical summary of the Physician Data Base of the Federation of State Medical Boards of the United States, Inc.~~

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. Financial 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 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.

~~Notwithstanding any other provision of this subsection, if the board contracts with the Commissioner of Education to provide funds for the costs of positions for which the State has contracted at the University of Vermont College of Medicine, or the Tufts University School of Medicine, the terms of the contract between the board and the commissioner must be in accordance with the requirements of Title 20-A, chapter 421;~~

Commented [TT2]: Legal counsels will see if this is still needed.

14. 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;

15. 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;

16. 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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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;

17. 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;

18. 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;

19. 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;

20. Authority to order a mental or physical examination. 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. Failure to comply with a direction of the committee to submit to a mental or physical examination results in the immediate suspension of the license of the individual until the individual submits to the examination.

21. 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.

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.

22. 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 [TT3]: This was moved from individual sections to cover all licensees

SUBCHAPTER 3

LICENSURE

§XXXX. Application; fees; general requirements

1. Application. An applicant seeking a license from the board must submit an application with the 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 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 ~~assistant~~associate licensed by the board who accepts the privilege of providing 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.

Failure to comply with a direction of the board or committee to submit to a mental or physical examination results in the immediate suspension of the license of the individual until the individual submits to the examination or if the individual is an applicant for licensure the denial of licensure.

Pursuant to Title 4, section 184, subsection 6, the District Court shall immediately suspend the license of a physician or physician ~~assistant~~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 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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

6. Licenses must be displayed. Each physician or physician ~~assistant~~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 ~~assistant~~associates

1. Qualification for licensure. The board may issue to an individual a license to practice as a physician ~~assistant~~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;
- (4) Does not have a license or certificate of registration 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 \$300; 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 ~~assistant~~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 ~~assistant~~associate;
- C. Requirements for collaborative agreements and practice agreements, including uniform standards and forms;
- D. Requirements for a physician ~~assistant~~associate to notify the board regarding certain circumstances, including but not limited to any change in address, the permanent departure of the physician ~~assistant~~associate from the State, any criminal convictions of the physician ~~assistant~~associate and any discipline by other jurisdictions of the physician ~~assistant~~associate;
- E. Issuance of temporary physician ~~assistant~~associate licenses;
- F. ~~Appointment of an advisory committee for continuing review of the physician assistant rules. The physician assistant members of the board must be members of the advisory committee;~~
- G. Continuing education requirements as a precondition to continued licensure or licensure renewal;
- H. Fees for the application for an initial physician ~~assistant~~associate license, which may not exceed \$300; and
- I. Fees for the biennial renewal of a physician ~~assistant~~associate license in an amount not to exceed

\$250.

§XXXX-B. Physician ~~assistant~~associate 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 ~~assistant~~associate under this

chapter. The board shall request a background check for each licensed physician ~~assistant~~associate who applies for an initial compact privilege and designates this State as the applicant's participating state from which the licensee is applying. 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~~associate 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~~associate 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 ~~Assistant Associates~~ 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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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

§XXXX. Full licensure of 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;

B. Graduate from an unaccredited medical school, be evaluated by the Educational Commission for Foreign Medical Graduates and receive a permanent certificate from the Educational Commission for Foreign Graduates; or

C. Graduate from an unaccredited medical school and achieve a passing score on the Visa Qualifying Examination or another comprehensive examination determined by the board to be substantially equivalent to the Visa Qualifying Examination.

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.

3. **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

Commented [TT4]: THE LCME stopped accrediting Canadian schools on 6/30/25. We need to discuss how to proceed with Canadian students.

Commented [TT5]: 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.

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.

4. 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.

5. Fees. Each applicant shall pay a fee up to \$600 plus the cost of the qualifying examination or examinations.

6. 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.

7. 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 must be paid 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.

~~**8. 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.~~

§XXXX. Full licensure of 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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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. 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.

4. Fees. An applicant must pay a fee up to \$600 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.

5. 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.

~~**6. Special license categories.** The board may issue a license limited to the practice of administrative medicine, or any other special license, as set forth by routine technical rule of the board adopted pursuant to Title 5, chapter 375, subchapter 2-A.~~

§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. 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. 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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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. 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. The fee for this license may be not more than \$300.

6. 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.

7. Contract students. An applicant who is qualified under section XXXX who received a medical education as a contract student as provided in Title 20-A, chapter 421, and who agrees to practice in a primary care or other specialized area as defined in Title 20-A, section 11803, subsection 2, or an underserved area as defined in Title 20-A, section 11802, is considered to have completed the postgraduate training requirements of section XXXX, subsection XXXX, upon satisfactory completion of at least 12 months in a graduate educational program approved as specified in section XXXX. The board may make the relicensure of an individual for 4 years after the individual's licensure under this subsection contingent on the individual's continuing to practice in an underserved area. This subsection applies only to individuals entering into a contract under Title 20-A, chapter 421, on or before December 31, 1984. The fee for this license may be not more than \$300.

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

1. Renewal of full licenses. A physician of physician ~~assistant~~associate with a full license issued by the board 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 full license renewal that is valid for no longer than 2 years.

A. Beginning with licenses expiring after July 1, 1994, regardless of the date of initial licensure or last license renewal, the license of every physician and physician ~~assistant~~associate born in an odd-numbered year expires at midnight in 1995 on the last day of the month of the individual's birth. The license of every physician and physician ~~assistant~~associate born in an even-numbered year expires at midnight in 1996 on the last day of the month of the individual's birth. Upon expiration, a physician or physician ~~assistant~~associate must renew the license issued pursuant to this section and this license must be renewed every 2 years by the last day of the month of birth of the individual

seeking license renewal 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 full 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 full license may be reinstated within 90 days after the date of expiration upon 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 full license, the license immediately and automatically lapses. The board may reinstate a full license that has lapsed pursuant to subsection 4.

2. Criteria for full 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 full license with the intent of conducting active medical practice 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 practice of medicine in this State in any degree, including advising or prescribing medication for self, friends or family with or without charge, 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 \$500 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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

4. Reinstatement after lapse. A full 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 full 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 full 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 practice of medicine continuously for at least the past 12 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 competency by passage of written examinations or practical demonstrations as the board may from time to time prescribe for this purpose through rulemaking.

§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.

§XXXX. Inactive license status

A licensee who wants to retain licensure while not practicing may apply for an inactive status license. During inactive status, the licensee must renew the license and pay the renewal fee set by rule

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 composition of investigative committees are subject to the following. An investigation committee must contain, if possible:

A. If the investigation involves allegations against an allopathic physician: Two allopathic physicians, one osteopathic physician, one physician ~~assistant~~associate, and one public member.

B. If the investigation involves allegations against an osteopathic physician: Two osteopathic physicians, one allopathic physician, one physician ~~assistant~~associate, and one public member.

C. If the investigation involves allegations against a physician ~~assistant~~associate: Three physician ~~assistant~~associates, one physician, and one public member.

2. **Powers and duties of an investigative committee.** An investigative committee of the board has the following powers and duties:

Commented [TT6]: There was discussion about the size and composition but nothing definitive was determined

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. Failure to comply with a direction of the committee to submit to a mental or physical examination results in the immediate suspension of the license of the individual until the individual submits to the examination.

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. Consent agreements may be entered into only with the consent of the applicant or licensee, the 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 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.

3. Adjudicatory hearings. 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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

§XXXX. Complaints; reports; investigations

1. 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. 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 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 by an individual who is not licensed under this chapter 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:
 - (1) 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
 - (2) 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 that has been established in the practice for which the licensee is licensed or authorized by the board;

Commented [TT7]: Is this phrase necessary?

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 narcotic or hypnotic or other drugs listed as controlled substances by the Drug Enforcement Administration for other than accepted therapeutic purposes;

K. Failure to report to the board a physician licensed under this chapter for addiction to alcohol or drugs or for mental illness in accordance with Title 24, section 2505, except when the impaired physician is or has been a patient of the licensee or the physician has been referred to the Medical Professionals Health Program;

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 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. 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;

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

P. 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;

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

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

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

2. Judicial review. Notwithstanding any provision of Title 10, section 8003, subsection 5-A to the contrary, any nonconsensual revocation pursuant to Title 10, section 8003, subsection 5-A 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-A, 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 ~~assistant~~associates

A physician or physician ~~assistant~~associate may delegate to the physician's or physician ~~assistant~~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 ~~assistant~~associate; the activities being delegated do not, unless otherwise provided by law, require a license, registration or certification to perform; the physician or physician ~~assistant~~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 ~~assistant~~associate ensures that the employees or support staff perform these delegated activities competently and safely. The physician or physician ~~assistant~~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 ~~assistant~~associate's agent. This section may not be construed to apply to registered nurses acting pursuant to Chapter 31 or physician ~~assistant~~associate acting pursuant to this chapter.

§XXXX Physician ~~assistant~~associates; scope of practice and agreement requirements

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

- A. "Collaborative agreement" means a document agreed to by a physician ~~assistant~~associate and a physician that describes the scope of practice for the physician ~~assistant~~associate 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.
- B. "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.
- C. "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~~associate, advanced practice nurse, nurse, physical therapist, occupational therapist, speech therapist, social worker, nutritionist, psychotherapist, counselor or other licensed professional.
- D. "Physician" means a person licensed by the board.
- E. "Physician ~~assistant~~associate" means a person licensed by the board. .
- F. "Practice agreement" means a document agreed to by a physician ~~assistant~~associate who is the principal clinical provider in a practice and a physician that states the physician will be available to the physician ~~assistant~~associate for collaboration or consultation.
- G. "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 under the federal Controlled Substances Act, 21 United States Code, Section 812.

2. Scope of practice. A physician ~~assistant~~associate may provide any medical service for which the physician ~~assistant~~associate has been prepared by education, training and experience and is competent to perform. The scope of practice of a physician ~~assistant~~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.

3. Dispensing drugs. Except for distributing a professional sample of a prescription or legend drug, a physician ~~assistant~~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.

4. Consultation. A physician ~~assistant~~associate shall, as indicated by a patient's condition, the education, competencies and experience of the physician ~~assistant~~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 ~~assistant~~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.

5. Collaborative agreement requirements. A physician ~~assistant~~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 ~~assistant~~associate's scope of practice, except that a physician ~~assistant~~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 ~~assistant~~associate is legally responsible and assumes legal liability for any medical service provided by the physician ~~assistant~~associate in accordance with the physician ~~assistant~~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 ~~assistant~~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 ~~assistant~~associate is no longer subject to the requirements of this subsection.

6. Practice agreement requirements. A physician ~~assistant~~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 ~~assistant~~associate has a practice agreement with an active physician, and other health care professionals as necessary, that describes the physician ~~assistant~~associate's scope of practice. A physician ~~assistant~~associate is legally responsible and assumes legal liability for any medical service provided by the physician ~~assistant~~associate in accordance with the physician ~~assistant~~associate's scope of practice under subsection 2 and a practice agreement under this subsection. A physician ~~assistant~~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 ~~assistant~~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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

physician ~~assistant~~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.

7. 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 ~~assistant~~associates, this section must be liberally construed to authorize physician ~~assistant~~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 ~~assistant~~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 ~~assistant~~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

An allopathic physician licensed pursuant to chapter 48, an osteopathic physician licensed pursuant to chapter 36, 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 Commissioners of the Profession 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.

DRAFT STATUTE FOR COMBINED MEDICAL 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. On or after January 1, 2017, 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. On or after January 1, 2017, 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 as a condition of prescribing 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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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 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 ~~assistant~~associates in Maine:

1. The Maine Board of Medicine is created and established by law. All references to, responsibilities of and authority conferred upon the 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 ~~assistant~~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.

Terranova, Tim E

From: [REDACTED]
Sent: Tuesday, August 19, 2025 6:04 AM
To: Terranova, Tim E
Subject: Maine Board Licensure in Medicine Concern

EXTERNAL: This email originated from outside of the State of Maine Mail System. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Good morning,

My name is Kerrigan Goudreau, and I am a second-year medical student at the University of New England College of Osteopathic Medicine as well as a lifelong Mainer. I am writing to share a concern I noticed on the Maine.gov Regulatory Licensing & Permitting website.

Currently, the Board of Licensure in Medicine search function, under the “Medicine” tab, only displays MD and PA providers. DO physicians, however, appear only under the separate “Osteopathic Licensure” tab. This division creates the impression that DO physicians are not fully licensed medical providers, when in fact DO and MD physicians hold equivalent practice rights in Maine and nationwide.

This separation is especially concerning in Maine, which ranks among the states with the highest ratio of DO physicians in the country. Many of these physicians serve in primary care and rural communities, making them essential to the health of our state—the most rural in the nation. Given that UNE COM is also a major contributor of physicians to Maine, I believe this division may inadvertently confuse patients and diminish trust in DO providers. For example, a patient searching for their osteopathic physician under the “Medicine” tab would not find them listed, which could raise unnecessary concerns about licensure.

I respectfully suggest that the website be updated so that DO physicians are also included under the “Medicine” category, or that the site language be revised to make clear that both MD and DO physicians are fully licensed to practice medicine in Maine.

I greatly appreciate your time and consideration of this matter, and I would be happy to discuss further if helpful.

Sincerely,

Kerrigan Goudreau (*she/her*) | OMS-II

Treasurer | *MSFC*

US Coordinator | *EM Club*



This e-mail may contain information that is privileged and confidential. If you suspect that you were not the intended recipient, please delete it and notify the sender as soon as possible.

Board of Licensure in Medicine - Board of Osteopathic Licensure
Workgroup
ZOOM meeting
September 24, 2025
5:30 p.m. – 6:31 p.m.

Board Members Present

Lisa Ryan, DO (BOL)
John Brewer, DO (BOL)
Melissa Michaud, PA (BOL)
Paul Vinsel, DO (BOL)
Christine Munroe, DO (BOL)
Public Member Lynne Weinstein (BOLIM)
Renée Fay-LeBlanc, MD (BOLIM)

Board Staff Present

Executive Secretary Rachel MacArthur (BOL)
Executive Director Timothy Terranova (BOLIM)
Administrative Assistant Maureen Lathrop (BOLIM)

Legal Counsel Present

Assistant Attorney General Lisa Wilson (BOL)
Assistant Attorney General Jennifer Willis (BOLIM)

A roll call of board members present was conducted.

BOL Comparison of draft statute and current statute

AAG Wilson noted that the renewal fee in the draft statute is not more than \$500, but the current statute allows a fee of up to \$600. Workgroup members agreed that having the licensing fee capped at a higher amount allows room to increase the fee if necessary.

In addition, osteopathic physicians over the age of 70 do not currently pay a renewal fee. Workgroup members agreed that practicing physicians, regardless of age, should pay a renewal fee. The workgroup discussed various suggestions including exempting current licensees over the age of 70 from being charged a renewal fee and prorating the license fee for licensees over the age of 70 who practice part-time.

Mr. Terranova stated that license fees for allopathic and osteopathic physicians should be standardized if the Boards merge. Actively practicing allopathic physicians pay a renewal fee regardless of age. He did note that physicians who retire from practice but wish to maintain their license have the option of an emeritus license with no fee.

Workgroup members were in favor of an emeritus license for all licensees.

AAG Wilson also noted that the draft statute did not include the notification requirement to a licensee when a FOIA request is made. (32 M.R.S. §2600-E in the current statute).

BOLIM Comparison of draft statute and current statute

AAG Willis noted differences in how an individual may use the term Dr. in the draft statute and the current BOLIM statute (32 M.R.S. § 3270).

In addition, the section in the draft statute regarding authority to order a mental or physical examination is much less detailed than current statute. Current statute lays out specific criteria and process (32 M.R.S. § 3286).

AAG Willis also noted that the section in the draft statute regarding disciplinary sanctions and judicial review is slightly different than current BOLIM statute.

AAG Willis recommended that a side-by-side comparison of the draft statute and current statute is an important step to be clear about moving away from current statute.

Letters from NBOME and MOA AOA

Mr. Terranova noted that the letters from the NBOME and MOA AOA were provided to the workgroup. The workgroup had no comments.

Next Steps

Ms. MacArthur noted that BOL recently received approval to add one staff member. There was discussion regarding the number of additional staff needed to adequately support the BOL. Ms. Michaud noted that it is important to be fiscally responsible and not overstaff the office. She requested budget figures for three employees – Ms. MacArthur, a medical director and one other employee for review at the next workgroup meeting.

Workgroup members asked if it is possible to get data from states where boards have merged and if it influenced license applications. Mr. Terranova will contact the FSMB to see if they can provide licensee numbers following board mergers.

The workgroup will need to conduct an in-depth side-by-side comparison of statutes at the October workgroup meeting. AAG Willis can assist BOLIM staff, AAG Wilson can assist BOL staff and Mr. Smith may be able to assist as well.

Mr. Terranova reminded workgroup members that the boards will need to vote at their November meetings whether they wish to merge or remain separate.

Public Comment

Robert Piccinini, DO, AOA President: Dr. Piccinini expressed concern regarding the section in the draft statute related to Investigative Committees composition. The draft contains the words “if possible” when specifying the number of allopathic, osteopathic, physician associate and public members to serve on committees. He noted that “if possible” is permissive and not mandatory. This means that osteopathic physicians could be investigated by committees with no osteopathic physicians, which is a concern because allopathic physicians do not understand osteopathic training and education.

Rich Thacker DO President Elect AOA: Dr. Thacker noted that he echoes the comments from Dr. Piccinini. Dr. Thacker stated that Florida statutes require that only an osteopathic physician can evaluate an osteopathic physician’s records. He indicated that Florida, Pennsylvania, Michigan, California, and

Oklahoma have independent osteopathic boards and osteopathic medical schools and large numbers of osteopathic physicians.

John Diefenderfer, DO: Dr. Diefenderfer stated that he respects all opinions on both boards. He disagrees that because some people get confused about two separate licensing boards that they should change identities. He has many patients that see him because he is an osteopathic physician with specific training. Second, he feels the Boards should continue to work together with unified voices but do not necessarily need to merge to do that. Dr. Diefenderfer also expressed concern that if language in the statute is not specific, osteopathic physicians specific identify may get lost. He encouraged the boards to stay separate and feels it is within reach to do so.

Next meeting is October 22, 2025 at 5:30 p.m.

Adjourn 6:31 p.m.

Board of Licensure in Medicine/Board of Osteopathic Licensure Workgroup
161 Capitol Street
Augusta, Maine 04333-0137
September 24, 2025
5:30 pm

The September 2025 meeting of the workgroup is being held 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 Board 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/85993292388>

Meeting ID: 859 9329 2388 Passcode: 35853215 or by phone (312) 626-6799 or 1 (646) 876-9923

-
- I. Introductions of Board Members and staff
 - II. BOL Comparison version draft statute (Dr., 3286 evaluations and renewal fees)
 - III. BOLIM Comparison version draft statute (Dr. & 3286 evaluations)
 - IV. Draft Statute for Combined Medical Boards working document
 - V. NBOME Letter to Workgroup
 - VI. AOA MOA Letter to Workgroup
 - VII. Next Steps
 - VIII. Public Comment
 - IX. Adjourn

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 Act."

§XXXX Purpose

The Maine Board of Medicine is the state regulatory agency charged with protecting the public through the licensing and regulation of physicians and physician assistants in Maine.

§XXXX. Definitions

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

1. Board. "Board" means the Maine Board of Medicine established in Title 5, section 12004-A, subsection X.

2. Commissioner. "Commissioner" means the Commissioner of Professional and Financial Regulation.

3. 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.

4. Physician. "Physician" means an allopathic or osteopathic physician licensed by the Board.

5. Physician Assistant. "Physician Assistant" means a physician assistant licensed by the Board.

6. 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, 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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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.

§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. License required

1. Unlicensed practice. 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.

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.

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, its sole purpose being to protect the public health and welfare. The board carries out this purpose by ensuring that the public is served by competent and honest practitioners and by establishing minimum standards of proficiency in the

professions regulated by the board by testing, licensing, regulating and disciplining practitioners of those regulated professions.

§XXXX. Board membership

1. Membership; terms; removal. The board consists of 17 members appointed by the Governor as follows:

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

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

C. Four physician assistants. Each physician assistant must hold a valid license under this chapter and must have been in the actual practice of medicine in this State for a continuous period of five (5) years immediately preceding appointment.

D. Three 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 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, rule making, 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. Adjudicatory hearing panels shall to the extent possible be composed of three members of the same license type as the respondent licensee and at least one public member.

4. Meetings. The board shall hold regular monthly meetings and any additional special meetings at a time and place the chair may designate.

5. Board Officers. The board shall elect the following officers, whose duties shall be enumerated by rule, to serve two-year terms: chair; vice-Chair, secretary. The secretary of the board shall perform such duties as delegated by the board, including but not limited to license application review functions.

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;

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;

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 mandated reports 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 as tabulated and categorized by the annual statistical summary of the Physician Data Base of the Federation of State Medical Boards of the United States, Inc.

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. Financial 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 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.

Notwithstanding any other provision of this subsection, if the board contracts with the Commissioner of Education to provide funds for the costs of positions for which the State has contracted at the University of Vermont College of Medicine, or the Tufts University School of Medicine, the terms of the contract between the board and the commissioner must be in accordance with the requirements of Title 20-A, chapter 421;

14. 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;

15. 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;

16. 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;

17. 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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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;

18. 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;

19. 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;

20. Authority to order a mental or physical examination. 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. Failure to comply with a direction of the committee to submit to a mental or physical examination results in the immediate suspension of the license of the individual until the individual submits to the examination.

21. 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.

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.

SUBCHAPTER 3

LICENSURE

§XXXX. Application; fees; general requirements

1. Application. An applicant seeking a license from the board must submit an application with the 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 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 assistant licensed by the board who accepts the privilege of providing 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.

Failure to comply with a direction of the board or committee to submit to a mental or physical examination results in the immediate suspension of the license of the individual until the individual submits to the examination or if the individual is an applicant for licensure the denial of licensure.

Pursuant to Title 4, section 184, subsection 6, the District Court shall immediately suspend the license of a physician or physician assistant 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 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 assistant 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 assistants

1. Qualification for licensure. The board may issue to an individual a license to practice as a physician assistant under the following conditions:

A. A license may be issued to an individual who:

(1) Graduated from a physician assistant program approved by the board;

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

- (2) Passed a physician assistant national certifying examination administered by the National Commission on Certification of Physician Assistants or its successor organization;
- (3) Demonstrates current clinical competency;
- (4) Does not have a license or certificate of registration 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 \$300; 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 assistants. 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 assistant;
- C. Requirements for collaborative agreements and practice agreements, including uniform standards and forms;
- D. Requirements for a physician assistant to notify the board regarding certain circumstances, including but not limited to any change in address, the permanent departure of the physician assistant from the State, any criminal convictions of the physician assistant and any discipline by other jurisdictions of the physician assistant;
- E. Issuance of temporary physician assistant licenses;
- F. Appointment of an advisory committee for continuing review of the physician assistant rules. The physician assistant members of the board must be members of the advisory committee;
- G. Continuing education requirements as a precondition to continued licensure or licensure renewal;
- H. Fees for the application for an initial physician assistant license, which may not exceed \$300; and
- I. Fees for the biennial renewal of a physician assistant license in an amount not to exceed \$250.

§XXXX-B. Physician assistant 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 assistant 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 from which the licensee is applying. 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 2A.

§XXXX. Full licensure of 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;

B. Graduate from an unaccredited medical school, be evaluated by the Educational Commission for Foreign Medical Graduates and receive a permanent certificate from the Educational Commission for Foreign Graduates; or

C. Graduate from an unaccredited medical school and achieve a passing score on the Visa Qualifying Examination or another comprehensive examination determined by the board to be substantially equivalent to the Visa Qualifying Examination.

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.

3. 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.

4. 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.

5. Fees. Each applicant shall pay a fee up to \$600 plus the cost of the qualifying examination or examinations.

6. 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.

7. 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 must be paid 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.

8. 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.

§XXXX. Full licensure of 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. 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.

4. Fees. An applicant must pay a fee up to \$600 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.

5. 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.

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

§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. 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. 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. 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. The fee for this license may be not more than \$300.

6. 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.

7. Contract students. An applicant who is qualified under section XXXX who received a medical education as a contract student as provided in Title 20-A, chapter 421, and who agrees to practice in a primary care or other specialized area as defined in Title 20-A, section 11803, subsection 2, or an underserved area as defined in Title 20-A, section 11802, is considered to have completed the postgraduate training requirements of section XXXX, subsection XXXX, upon satisfactory completion of at least 12 months in a graduate educational program approved as specified in section XXXX. The board may make the relicensure of an individual for 4 years after the individual's licensure under this subsection contingent on the individual's continuing to practice in an underserved area. This subsection applies only to individuals entering into a contract under Title 20-A, chapter 421, on or before December 31, 1984. The fee for this license may be not more than \$300.

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

1. Renewal of full licenses. A physician or physician assistant with a full license issued by the board 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 full license renewal that is valid for no longer than 2 years.

A. Beginning with licenses expiring after July 1, 1994, regardless of the date of initial licensure or last license renewal, the license of every physician and physician assistant born in an odd-numbered year expires at midnight in 1995 on the last day of the month of the individual's birth. The license of every physician and physician assistant born in an even-numbered year expires at midnight in 1996 on the last day of the month of the individual's birth. Upon expiration, a physician or physician assistant must renew the license issued pursuant to this section and this license must be renewed every 2 years by the last day of the month of birth of the individual seeking license renewal 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 full 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 full license may be reinstated within 90 days after the date of expiration upon 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 full license, the license immediately and automatically lapses. The board may reinstate a full license that has lapsed pursuant to subsection 4.

2. Criteria for full 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 full license with the intent of conducting active medical practice 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 practice of medicine in this State in any degree, including advising or prescribing medication for self, friends or family with or without charge, 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 \$500 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 full 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 full 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 full 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 practice of medicine continuously for at least the past 12 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 competency by passage of written examinations or practical demonstrations as the board may from time to time prescribe for this purpose through rulemaking.

§XXXX. Withdrawal of license

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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.

§XXXX. Inactive license status

A licensee who wants to retain licensure while not practicing may apply for an inactive status license. During inactive status, the licensee must renew the license and pay the renewal fee set by rule

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 composition of investigative committees are subject to the following. An investigation committee must contain, if possible:

A. If the investigation involves allegations against an allopathic physician: Two allopathic physicians, one osteopathic physician, one physician assistant, and one public member.

B. If the investigation involves allegations against an osteopathic physician: Two osteopathic physicians, one allopathic physician, one physician assistant, and one public member.

C. If the investigation involves allegations against a physician assistant: Three physician assistants, one physician, and one public member.

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. Failure to comply with a direction of the committee to submit to a mental or physical examination results in the immediate suspension of the license of the individual until the individual submits to the examination.

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. Consent agreements may be entered into only with the consent of the applicant or licensee, the 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 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.

3. Adjudicatory hearings. 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.

§XXXX. Complaints; reports; investigations

1. 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. 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 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 by an individual who is not licensed under this chapter 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:
 - (1) 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
 - (2) 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 that has been established in the practice for which the licensee is licensed or authorized by the board;
- 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 narcotic or hypnotic or other drugs listed as controlled substances by the Drug Enforcement Administration for other than accepted therapeutic purposes;
- K. Failure to report to the board a physician licensed under this chapter for addiction to alcohol or drugs or for mental illness in accordance with Title 24, section 2505, except when the impaired physician is or has been a patient of the licensee or the physician has been referred to the Medical Professionals Health Program;
- 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 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. 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;
- O. Noncompliance with an order of or consent agreement executed by the board;
- P. 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;
- Q. Failure to timely respond to a complaint notification sent by the board;
- R. Failure to comply with the requirements of Title 22, section 7253;
- S. Advertising, offering or administering conversion therapy to a minor.

2. Judicial review. Notwithstanding any provision of Title 10, section 8003, subsection 5-A to the contrary, any nonconsensual revocation pursuant to Title 10, section 8003, subsection 5-A 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-A, 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 assistants

A physician or physician assistant may delegate to the physician's or physician assistant'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 assistant; the activities being delegated do not, unless otherwise provided by law, require a license, registration or certification to perform; the physician or physician assistant 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 assistant ensures that the employees or support staff perform these delegated activities competently and safely. The physician or physician assistant 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 assistant's agent. This section may not be construed to apply to registered nurses acting pursuant to Chapter 31 or physician assistant acting pursuant to this chapter.

§XXXX Physician assistants; scope of practice and agreement requirements

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Collaborative agreement" means a document agreed to by a physician assistant 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.

B. "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.

C. "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.

D. "Physician" means a person licensed by the board.

E. "Physician assistant" means a person licensed by the board. .

F. "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.

G. "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 under the federal Controlled Substances Act, 21 United States Code, Section 812.

2. Scope of practice. A physician assistant may provide any medical service for which the physician assistant has been prepared by education, training and experience and is competent to perform. The scope of practice of a physician assistant 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.

3. Dispensing drugs. Except for distributing a professional sample of a prescription or legend drug, a physician assistant 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.

4. Consultation. A physician assistant shall, as indicated by a patient's condition, the education, competencies and experience of the physician assistant 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 assistant 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.

5. Collaborative agreement requirements. A physician assistant 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 assistant's scope of practice, except that a physician assistant 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 assistant is legally responsible and assumes legal liability for any medical service provided by the physician assistant in accordance with the physician assistant'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 assistant 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 assistant is no longer subject to the requirements of this subsection.

6. Practice agreement requirements. A physician assistant 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 assistant has a practice agreement with an active physician, and other health care professionals as necessary, that describes the physician assistant's scope of practice. A physician assistant is legally responsible and assumes legal liability for any medical service provided by the physician assistant in accordance with the physician assistant's scope of practice under subsection 2 and a practice agreement under this subsection. A physician assistant 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 assistant'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 assistant 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.

7. 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 assistants, this section must be liberally construed to authorize physician assistants 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 assistant 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 assistant'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

An allopathic physician licensed pursuant to chapter 48, an osteopathic physician licensed pursuant to chapter 36, 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 Commissioners of the Profession 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

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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. On or after January 1, 2017, 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. On or after January 1, 2017, 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 as a condition of prescribing 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 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 assistants in Maine:

1. The Maine Board of Medicine is created and established by law. All references to, responsibilities of and authority conferred upon the 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 assistants 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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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.

§2581. Licenses; biennial relicensure; fees; reinstatement

Upon satisfactorily qualifying for licensure, the applicant may be issued a license by the board, which is dated and signed by its members and upon which the official seal of the board is affixed. The license must designate the holder as a physician licensed to practice osteopathic medicine in the State of Maine. The license must be publicly displayed at the individual's principal place of practice. [PL 1993, c. 600, Pt. A, §180 (AMD).]

Every osteopathic physician legally licensed to practice in this State, shall, on or before the expiration date of the osteopathic physician's license, pay to the board a fee set by the board not to exceed \$600 for the renewal of the osteopathic physician's license to practice. An osteopathic physician's license is issued for a period of 2 years and must be renewed in accordance with a schedule adopted by the board by rule. Rules adopted pursuant to this section are routine technical rules pursuant to Title 5, chapter 375, subchapter II-A. In addition to the payment of the renewal fee, each licensee applying for the renewal of the osteopathic physician's license shall furnish to the board satisfactory evidence that the osteopathic physician has attended in the 2 preceding years at least 100 hours of educational programs devoted to continuing medical education approved by the board. The required education must be obtained from formalized programs of continuing medical education sponsored by recognized associations, colleges or universities, hospitals, institutes or groups approved by the board. A copy of the current approved list must be available in the office of the secretary-treasurer of the board. At least 40% of these credit hours must be osteopathic medical education approved in the rules established by the board. The board may adjudicate continuing medical education performance in situations of illness, hardship or military service upon written petition by the applicant. The secretary-treasurer of the board shall send a written notice of the foregoing requirements to each osteopathic physician, at least 60 days prior to each osteopathic physician's license expiration date, directed to the last known address of the licensee and enclosing with the notice proper blank forms for application for renewal. If a licensee fails to furnish the board evidence of attendance at continuing medical educational programs, as approved by the board, fails to pay the renewal fee or fails to submit a completed application for renewal, the osteopathic physician automatically forfeits the right to practice osteopathic medicine in this State. After the expiration of a license, the board shall send notice by first class mail to each licensee who has failed to meet the requirements for renewal. If the failure is not corrected within 30 days, then the osteopathic physician's license may be considered lapsed by the board. The secretary-treasurer of the board may reinstate the osteopathic physician upon the presentation of satisfactory evidence of continuing medical education as outlined and approved by the board and upon payment of the renewal fee. [PL 2001, c. 492, §6 (AMD).]

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 obtain osteopathic continuous certification as a condition of licensure. For the purposes of this section, "osteopathic continuous certification" means a program that requires an osteopathic physician to engage in periodic examination, self-assessment, peer evaluation or other activities to maintain certification from a specialty medical board. [PL 2017, c. 189, §1 (NEW).]

Relicensure fees provided for under this section are not required of an osteopathic physician who is 70 years of age or older on the first day of January of the year in which the relicensure is made, although the requirements for continuing medical education apply without regard to age. [PL 1993, c. 600, Pt. A, §180 (AMD).]

The license entitles an individual to whom it is granted the privilege to practice osteopathic medicine in any county in this State, in all its branches as taught in a school or college of osteopathic medicine approved by the American Osteopathic Association with the right to use drugs that are necessary in the practice of osteopathic medicine. [PL 1997, c. 50, §8 (AMD).]

An individual to whom a license is granted under this section shall designate that individual's status as an osteopathic physician either by the letters D.O. following the licensee's name or by the words "osteopathic physician" following or accompanying the licensee's name when the prefix Doctor or Dr. is used. [PL 1993, c. 600, Pt. A, §180 (AMD).]

An applicant not complying with relicensure requirements is entitled to be reinstated upon paying the relicensure fee for the given year and satisfying the board that the applicant has paid all relicensure fees due at the time of the applicant's withdrawal, and that a cause does not exist for revoking or suspending the applicant's license. The board shall determine the skill and competence of an osteopathic physician applying for a reinstatement who has not been engaged in the active practice of osteopathic medicine in this or some other state for a period in excess of **one year** from the date of the physician's most recent relicensure in Maine. [PL 1993, c. 600, Pt. A, §180 (AMD).]

SECTION HISTORY

PL 1973, c. 374, §1 (NEW). PL 1985, c. 804, §§18,22 (AMD). PL 1989, c. 462, §6 (AMD). PL 1991, c. 425, §8 (AMD). PL 1993, c. 600, §A180 (AMD). PL 1997, c. 50, §8 (AMD). PL 2001, c. 492, §6 (AMD). PL 2017, c. 189, §1 (AMD).

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§2600-E. 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.

[PL 2019, c. 499, §2 (NEW).]

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 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, §2 (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, §2 (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, §2 (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, §2 (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, §2 (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.

[PL 2019, c. 499, §2 (NEW).]

SECTION HISTORY

PL 2019, c. 499, §2 (NEW).

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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 Act."

§XXXX Purpose

The Maine Board of Medicine is the state regulatory agency charged with protecting the public through the licensing and regulation of physicians and physician assistants in Maine.

§XXXX. Definitions

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

1. Board. "Board" means the Maine Board of Medicine established in Title 5, section 12004-A, subsection X.

2. Commissioner. "Commissioner" means the Commissioner of Professional and Financial Regulation.

3. 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.

4. Physician. "Physician" means an allopathic or osteopathic physician licensed by the Board.

5. Physician Assistant. "Physician Assistant" means a physician assistant licensed by the Board.

6. 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, 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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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.

§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. License required

1. Unlicensed practice. 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.

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.

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, its sole purpose being to protect the public health and welfare. The board carries out this purpose by ensuring that the public is served by competent and honest practitioners and by establishing minimum standards of proficiency in the

professions regulated by the board by testing, licensing, regulating and disciplining practitioners of those regulated professions.

§XXXX. Board membership

1. Membership; terms; removal. The board consists of 17 members appointed by the Governor as follows:

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

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

C. Four physician assistants. Each physician assistant must hold a valid license under this chapter and must have been in the actual practice of medicine in this State for a continuous period of five (5) years immediately preceding appointment.

D. Three 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 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, rule making, 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. Adjudicatory hearing panels shall to the extent possible be composed of three members of the same license type as the respondent licensee and at least one public member.

4. Meetings. The board shall hold regular monthly meetings and any additional special meetings at a time and place the chair may designate.

5. Board Officers. The board shall elect the following officers, whose duties shall be enumerated by rule, to serve two-year terms: chair; vice-Chair, secretary. The secretary of the board shall perform such duties as delegated by the board, including but not limited to license application review functions.

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;

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;

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 mandated reports 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 as tabulated and categorized by the annual statistical summary of the Physician Data Base of the Federation of State Medical Boards of the United States, Inc.

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. Financial 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 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.

Notwithstanding any other provision of this subsection, if the board contracts with the Commissioner of Education to provide funds for the costs of positions for which the State has contracted at the University of Vermont College of Medicine, or the Tufts University School of Medicine, the terms of the contract between the board and the commissioner must be in accordance with the requirements of Title 20-A, chapter 421;

14. 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;

15. 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;

16. 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;

17. 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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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;

18. 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;

19. 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;

20. Authority to order a mental or physical examination. 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. Failure to comply with a direction of the committee to submit to a mental or physical examination results in the immediate suspension of the license of the individual until the individual submits to the examination.

21. 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.

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.

SUBCHAPTER 3

LICENSURE

§XXXX. Application; fees; general requirements

1. Application. An applicant seeking a license from the board must submit an application with the 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 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 assistant licensed by the board who accepts the privilege of providing 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.

Failure to comply with a direction of the board or committee to submit to a mental or physical examination results in the immediate suspension of the license of the individual until the individual submits to the examination or if the individual is an applicant for licensure the denial of licensure.

Pursuant to Title 4, section 184, subsection 6, the District Court shall immediately suspend the license of a physician or physician assistant 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 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 assistant 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 assistants

1. Qualification for licensure. The board may issue to an individual a license to practice as a physician assistant under the following conditions:

A. A license may be issued to an individual who:

(1) Graduated from a physician assistant program approved by the board;

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

- (2) Passed a physician assistant national certifying examination administered by the National Commission on Certification of Physician Assistants or its successor organization;
- (3) Demonstrates current clinical competency;
- (4) Does not have a license or certificate of registration 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 \$300; 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 assistants. 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 assistant;
- C. Requirements for collaborative agreements and practice agreements, including uniform standards and forms;
- D. Requirements for a physician assistant to notify the board regarding certain circumstances, including but not limited to any change in address, the permanent departure of the physician assistant from the State, any criminal convictions of the physician assistant and any discipline by other jurisdictions of the physician assistant;
- E. Issuance of temporary physician assistant licenses;
- F. Appointment of an advisory committee for continuing review of the physician assistant rules. The physician assistant members of the board must be members of the advisory committee;
- G. Continuing education requirements as a precondition to continued licensure or licensure renewal;
- H. Fees for the application for an initial physician assistant license, which may not exceed \$300; and
- I. Fees for the biennial renewal of a physician assistant license in an amount not to exceed \$250.

§XXXX-B. Physician assistant 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 assistant 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 from which the licensee is applying. 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 2A.

§XXXX. Full licensure of 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;

B. Graduate from an unaccredited medical school, be evaluated by the Educational Commission for Foreign Medical Graduates and receive a permanent certificate from the Educational Commission for Foreign Graduates; or

C. Graduate from an unaccredited medical school and achieve a passing score on the Visa Qualifying Examination or another comprehensive examination determined by the board to be substantially equivalent to the Visa Qualifying Examination.

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.

3. 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.

4. 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.

5. Fees. Each applicant shall pay a fee up to \$600 plus the cost of the qualifying examination or examinations.

6. 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.

7. 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 must be paid 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.

8. 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.

§XXXX. Full licensure of 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. 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.

4. Fees. An applicant must pay a fee up to \$600 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.

5. 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.

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

§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. 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. 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. 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. The fee for this license may be not more than \$300.

6. 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.

7. Contract students. An applicant who is qualified under section XXXX who received a medical education as a contract student as provided in Title 20-A, chapter 421, and who agrees to practice in a primary care or other specialized area as defined in Title 20-A, section 11803, subsection 2, or an underserved area as defined in Title 20-A, section 11802, is considered to have completed the postgraduate training requirements of section XXXX, subsection XXXX, upon satisfactory completion of at least 12 months in a graduate educational program approved as specified in section XXXX. The board may make the relicensure of an individual for 4 years after the individual's licensure under this subsection contingent on the individual's continuing to practice in an underserved area. This subsection applies only to individuals entering into a contract under Title 20-A, chapter 421, on or before December 31, 1984. The fee for this license may be not more than \$300.

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

1. Renewal of full licenses. A physician or physician assistant with a full license issued by the board 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 full license renewal that is valid for no longer than 2 years.

A. Beginning with licenses expiring after July 1, 1994, regardless of the date of initial licensure or last license renewal, the license of every physician and physician assistant born in an odd-numbered year expires at midnight in 1995 on the last day of the month of the individual's birth. The license of every physician and physician assistant born in an even-numbered year expires at midnight in 1996 on the last day of the month of the individual's birth. Upon expiration, a physician or physician assistant must renew the license issued pursuant to this section and this license must be renewed every 2 years by the last day of the month of birth of the individual seeking license renewal 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 full 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 full license may be reinstated within 90 days after the date of expiration upon 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 full license, the license immediately and automatically lapses. The board may reinstate a full license that has lapsed pursuant to subsection 4.

2. Criteria for full 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 full license with the intent of conducting active medical practice 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 practice of medicine in this State in any degree, including advising or prescribing medication for self, friends or family with or without charge, 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 \$500 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 full 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 full 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 full 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 practice of medicine continuously for at least the past 12 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 competency by passage of written examinations or practical demonstrations as the board may from time to time prescribe for this purpose through rulemaking.

§XXXX. Withdrawal of license

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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.

§XXXX. Inactive license status

A licensee who wants to retain licensure while not practicing may apply for an inactive status license. During inactive status, the licensee must renew the license and pay the renewal fee set by rule

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 composition of investigative committees are subject to the following. An investigation committee must contain, if possible:

A. If the investigation involves allegations against an allopathic physician: Two allopathic physicians, one osteopathic physician, one physician assistant, and one public member.

B. If the investigation involves allegations against an osteopathic physician: Two osteopathic physicians, one allopathic physician, one physician assistant, and one public member.

C. If the investigation involves allegations against a physician assistant: Three physician assistants, one physician, and one public member.

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. Failure to comply with a direction of the committee to submit to a mental or physical examination results in the immediate suspension of the license of the individual until the individual submits to the examination.

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. Consent agreements may be entered into only with the consent of the applicant or licensee, the 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 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.

3. Adjudicatory hearings. 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.

§XXXX. Complaints; reports; investigations

1. 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. 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 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 by an individual who is not licensed under this chapter 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:
 - (1) 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
 - (2) 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 that has been established in the practice for which the licensee is licensed or authorized by the board;
- 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 narcotic or hypnotic or other drugs listed as controlled substances by the Drug Enforcement Administration for other than accepted therapeutic purposes;
- K. Failure to report to the board a physician licensed under this chapter for addiction to alcohol or drugs or for mental illness in accordance with Title 24, section 2505, except when the impaired physician is or has been a patient of the licensee or the physician has been referred to the Medical Professionals Health Program;
- 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 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. 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;
- O. Noncompliance with an order of or consent agreement executed by the board;
- P. 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;
- Q. Failure to timely respond to a complaint notification sent by the board;
- R. Failure to comply with the requirements of Title 22, section 7253;
- S. Advertising, offering or administering conversion therapy to a minor.

2. Judicial review. Notwithstanding any provision of Title 10, section 8003, subsection 5-A to the contrary, any nonconsensual revocation pursuant to Title 10, section 8003, subsection 5-A 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-A, 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 assistants

A physician or physician assistant may delegate to the physician's or physician assistant'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 assistant; the activities being delegated do not, unless otherwise provided by law, require a license, registration or certification to perform; the physician or physician assistant 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 assistant ensures that the employees or support staff perform these delegated activities competently and safely. The physician or physician assistant 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 assistant's agent. This section may not be construed to apply to registered nurses acting pursuant to Chapter 31 or physician assistant acting pursuant to this chapter.

§XXXX Physician assistants; scope of practice and agreement requirements

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Collaborative agreement" means a document agreed to by a physician assistant 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.

B. "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.

C. "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.

D. "Physician" means a person licensed by the board.

E. "Physician assistant" means a person licensed by the board. .

F. "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.

G. "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 under the federal Controlled Substances Act, 21 United States Code, Section 812.

2. Scope of practice. A physician assistant may provide any medical service for which the physician assistant has been prepared by education, training and experience and is competent to perform. The scope of practice of a physician assistant 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.

3. Dispensing drugs. Except for distributing a professional sample of a prescription or legend drug, a physician assistant 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.

4. Consultation. A physician assistant shall, as indicated by a patient's condition, the education, competencies and experience of the physician assistant 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 assistant 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.

5. Collaborative agreement requirements. A physician assistant 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 assistant's scope of practice, except that a physician assistant 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 assistant is legally responsible and assumes legal liability for any medical service provided by the physician assistant in accordance with the physician assistant'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 assistant 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 assistant is no longer subject to the requirements of this subsection.

6. Practice agreement requirements. A physician assistant 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 assistant has a practice agreement with an active physician, and other health care professionals as necessary, that describes the physician assistant's scope of practice. A physician assistant is legally responsible and assumes legal liability for any medical service provided by the physician assistant in accordance with the physician assistant's scope of practice under subsection 2 and a practice agreement under this subsection. A physician assistant 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 assistant'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 assistant 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.

7. 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 assistants, this section must be liberally construed to authorize physician assistants 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 assistant 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 assistant'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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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

An allopathic physician licensed pursuant to chapter 48, an osteopathic physician licensed pursuant to chapter 36, 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 Commissioners of the Profession 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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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. On or after January 1, 2017, 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. On or after January 1, 2017, 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 as a condition of prescribing 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 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 assistants in Maine:

1. The Maine Board of Medicine is created and established by law. All references to, responsibilities of and authority conferred upon the 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 assistants 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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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.

§3270. Licensure required

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. An individual licensed under chapter 36 may prefix the title "Doctor" or the letters "Dr." to that individual's name, as provided in section 2581, or a chiropractor licensed by this State may prefix the title "Doctor" or the letters "Dr." to that individual's name when accompanied by the word "Chiropractor," or a dentist duly licensed by this State may prefix the title "Doctor" or the letters "Dr." to that individual's name or a naturopathic doctor licensed by this State may prefix the title "Doctor" or the letters "Dr." to that individual's name when accompanied by the word "Naturopathy" or the words "Naturopathic Medicine" or an optometrist duly licensed under the laws of this State may prefix the title "Doctor" or the letters "Dr." to that individual's name when accompanied by the word "Optometrist" or a podiatrist licensed under the laws of this State may prefix the title "Doctor" or the letters "Dr." to that individual's name when accompanied by the word "Podiatrist" or "Chiropodist." [PL 1995, c. 671, §11 (AMD).]

Whoever, not being duly licensed by the board, practices medicine or surgery or a branch of medicine or surgery, or purports to practice medicine or surgery or a branch of medicine or surgery in a way cited in this section, or who uses the title "Doctor" or the letters "Dr." or the letters "M.D." in connection with that individual's name, contrary to this section, commits a Class E crime. Nothing contained in this section prevents an individual who has received the doctor's degree from a reputable college or university, other than the degree of "Doctor of Medicine" from prefixing the letters "Dr." to that individual's name, if that individual is not engaged, and does not engage, in the practice of medicine or surgery or the treatment of a disease or human ailment. Nothing contained in this section prevents an individual who has received the degree "Doctor of Medicine" from a reputable college or university but who is not engaged in the practice of medicine or surgery or the treatment of a disease or human ailment, from prefixing the letters "Dr." or appending the letters "M.D." to that individual's name, as long as that individual's license to practice has never been revoked by the board. Nothing in this chapter may be construed as to affect or prevent the practice of the religious tenets of a church in the ministration to the sick or suffering by mental or spiritual means. [PL 2015, c. 270, §1 (AMD).]

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. Unless otherwise specified, the board shall set the fees. [PL 1991, c. 425, §12 (NEW).]

SECTION HISTORY

PL 1971, c. 591, §1 (NEW). PL 1973, c. 788, §161 (AMD). PL 1991, c. 425, §12 (AMD). PL 1991, c. 797, §17 (AMD). PL 1993, c. 600, §A204 (AMD). PL 1995, c. 671, §11 (AMD). PL 2015, c. 270, §1 (AMD).

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§3286. Emergency action

Upon its own motion or upon complaint, 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 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. [PL 2013, c. 355, §13 (AMD).]

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. [PL 2013, c. 355, §14 (AMD).]

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. [PL 1993, c. 600, Pt. A, §219 (AMD).]

SECTION HISTORY

PL 1971, c. 591, §1 (NEW). PL 1981, c. 594, §2 (AMD). PL 1993, c. 600, §A219 (AMD). PL 1997, c. 271, §11 (AMD). PL 2013, c. 355, §§13, 14 (AMD).

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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 Act."

§XXXX Purpose

The Maine Board of Medicine is the state regulatory agency charged with protecting the public through the licensing and regulation of physicians and physician ~~assistant~~associates in Maine.

§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.

1. **Board.** "Board" means the Maine Board of Medicine established in Title 5, section 12004-A, subsection X.

2. **Commissioner.** "Commissioner" means the Commissioner of Professional and Financial Regulation.

3. **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.

4. **Osteopathic Physician.** "Osteopathic Physician" means a physician who graduated from medical school with a DO degree.

4. **Physician.** "Physician" means an allopathic or osteopathic physician licensed by the Board.

5. **Physician ~~Assistant~~Associate.** "Physician ~~Assistant~~Associate" means a physician ~~assistant~~associate licensed by the Board.

6. **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, 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;

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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.

I. The rendering of medical services by physician associates

§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. License required

1. Unlicensed practice. 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.

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.

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, its sole purpose being to protect the public health and welfare. The board carries out this purpose by ensuring that the public is served by competent and honest practitioners and by establishing minimum standards of proficiency in the professions regulated by the board by testing, licensing, regulating and disciplining practitioners of those regulated professions.

§XXXX. Board membership

1. Membership; terms; removal. The board consists of 17 members appointed by the Governor as follows:

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

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

C. Four physician ~~assistant associates~~. Each physician ~~assistant associate~~ must hold a valid license under this chapter and must have been in the actual practice of medicine in this State for a continuous period of five (5) years immediately preceding appointment.

D. Three 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 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, rule making, 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. Adjudicatory hearing panels shall to the extent possible be composed of three members of the same license type as the respondent licensee and at least one public member.~~

4. Meetings. The board shall hold ~~regular monthly meetings~~ a minimum of three regular meetings a year and any additional special meetings at a time and place the chair may designate.

Commented [TT1]: There was discussion about the size and composition panel but nothing definitive was determined.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

5. Board Officers. The board shall elect the following officers, whose duties shall be enumerated by rule, to serve two-year terms: chair; vice-Chair, secretary. The secretary of the board shall perform such duties as delegated by the board ~~through rule, including but not limited to license application review functions.~~

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;

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;

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 mandated reports 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 as tabulated and categorized by the annual statistical summary of the Physician Data Base of the Federation of State Medical Boards of the United States, Inc.~~

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. Financial 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 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.

~~Notwithstanding any other provision of this subsection, if the board contracts with the Commissioner of Education to provide funds for the costs of positions for which the State has contracted at the University of Vermont College of Medicine, or the Tufts University School of Medicine, the terms of the contract between the board and the commissioner must be in accordance with the requirements of Title 20-A, chapter 421;~~

Commented [TT2]: Legal counsels will see if this is still needed.

14. 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;

15. 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;

16. 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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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;

17. 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;

18. 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;

19. 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;

20. Authority to order a mental or physical examination. 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. Failure to comply with a direction of the committee to submit to a mental or physical examination results in the immediate suspension of the license of the individual until the individual submits to the examination.

21. 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.

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.

22. 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 [TT3]: This was moved from individual sections to cover all licensees

SUBCHAPTER 3

LICENSURE

§XXXX. Application; fees; general requirements

1. Application. An applicant seeking a license from the board must submit an application with the 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 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 ~~assistant~~associate licensed by the board who accepts the privilege of providing 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.

Failure to comply with a direction of the board or committee to submit to a mental or physical examination results in the immediate suspension of the license of the individual until the individual submits to the examination or if the individual is an applicant for licensure the denial of licensure.

Pursuant to Title 4, section 184, subsection 6, the District Court shall immediately suspend the license of a physician or physician ~~assistant~~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 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.

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 Act."

§XXXX Purpose

The Maine Board of Medicine is the state regulatory agency charged with protecting the public through the licensing and regulation of physicians and physician ~~assistant~~associates in Maine.

§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.

1. **Board.** "Board" means the Maine Board of Medicine established in Title 5, section 12004-A, subsection X.

2. **Commissioner.** "Commissioner" means the Commissioner of Professional and Financial Regulation.

3. **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.

4. **Osteopathic Physician.** "Osteopathic Physician" means a physician who graduated from medical school with a DO degree.

4. **Physician.** "Physician" means an allopathic or osteopathic physician licensed by the Board.

5. **Physician ~~Assistant~~Associate.** "Physician ~~Assistant~~Associate" means a physician ~~assistant~~associate licensed by the Board.

6. **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, 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;

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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.

I. The rendering of medical services by physician associates

§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. License required

1. Unlicensed practice. 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.

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.

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, its sole purpose being to protect the public health and welfare. The board carries out this purpose by ensuring that the public is served by competent and honest practitioners and by establishing minimum standards of proficiency in the professions regulated by the board by testing, licensing, regulating and disciplining practitioners of those regulated professions.

§XXXX. Board membership

1. Membership; terms; removal. The board consists of 17 members appointed by the Governor as follows:

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

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

C. Four physician ~~assistant associates~~. Each physician ~~assistant associate~~ must hold a valid license under this chapter and must have been in the actual practice of medicine in this State for a continuous period of five (5) years immediately preceding appointment.

D. Three 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 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, rule making, 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. Adjudicatory hearing panels shall to the extent possible be composed of three members of the same license type as the respondent licensee and at least one public member.~~

4. Meetings. The board shall hold ~~regular monthly meetings~~ a minimum of three regular meetings a year and any additional special meetings at a time and place the chair may designate.

Commented [TT1]: There was discussion about the size and composition panel but nothing definitive was determined.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

5. Board Officers. The board shall elect the following officers, whose duties shall be enumerated by rule, to serve two-year terms: chair; vice-Chair, secretary. The secretary of the board shall perform such duties as delegated by the board ~~through rule, including but not limited to license application review functions.~~

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;

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;

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 mandated reports 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 as tabulated and categorized by the annual statistical summary of the Physician Data Base of the Federation of State Medical Boards of the United States, Inc.~~

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. Financial 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 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.

~~Notwithstanding any other provision of this subsection, if the board contracts with the Commissioner of Education to provide funds for the costs of positions for which the State has contracted at the University of Vermont College of Medicine, or the Tufts University School of Medicine, the terms of the contract between the board and the commissioner must be in accordance with the requirements of Title 20-A, chapter 421;~~

Commented [TT2]: Legal counsels will see if this is still needed.

14. 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;

15. 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;

16. 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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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;

17. 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;

18. 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;

19. 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;

20. Authority to order a mental or physical examination. 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. Failure to comply with a direction of the committee to submit to a mental or physical examination results in the immediate suspension of the license of the individual until the individual submits to the examination.

21. 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.

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.

22. 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.

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SUBCHAPTER 3

LICENSURE

§XXXX. Application; fees; general requirements

1. Application. An applicant seeking a license from the board must submit an application with the 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 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 ~~assistant~~associate licensed by the board who accepts the privilege of providing 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.

Failure to comply with a direction of the board or committee to submit to a mental or physical examination results in the immediate suspension of the license of the individual until the individual submits to the examination or if the individual is an applicant for licensure the denial of licensure.

Pursuant to Title 4, section 184, subsection 6, the District Court shall immediately suspend the license of a physician or physician ~~assistant~~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 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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

6. Licenses must be displayed. Each physician or physician ~~assistant~~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 ~~assistant~~associates

1. Qualification for licensure. The board may issue to an individual a license to practice as a physician ~~assistant~~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;
- (4) Does not have a license or certificate of registration 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 \$300; 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 ~~assistant~~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 ~~assistant~~associate;
- C. Requirements for collaborative agreements and practice agreements, including uniform standards and forms;
- D. Requirements for a physician ~~assistant~~associate to notify the board regarding certain circumstances, including but not limited to any change in address, the permanent departure of the physician ~~assistant~~associate from the State, any criminal convictions of the physician ~~assistant~~associate and any discipline by other jurisdictions of the physician ~~assistant~~associate;
- E. Issuance of temporary physician ~~assistant~~associate licenses;
- F. ~~Appointment of an advisory committee for continuing review of the physician assistant rules. The physician assistant members of the board must be members of the advisory committee;~~
- G. Continuing education requirements as a precondition to continued licensure or licensure renewal;
- H. Fees for the application for an initial physician ~~assistant~~associate license, which may not exceed \$300; and
- I. Fees for the biennial renewal of a physician ~~assistant~~associate license in an amount not to exceed

\$250.

§XXXX-B. Physician ~~assistant~~associate 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 ~~assistant~~associate under this

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

6. Licenses must be displayed. Each physician or physician ~~assistant~~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.

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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;
- (4) Does not have a license or certificate of registration 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 \$300; 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 ~~assistant~~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 ~~assistant~~associate;
- C. Requirements for collaborative agreements and practice agreements, including uniform standards and forms;
- D. Requirements for a physician ~~assistant~~associate to notify the board regarding certain circumstances, including but not limited to any change in address, the permanent departure of the physician ~~assistant~~associate from the State, any criminal convictions of the physician ~~assistant~~associate and any discipline by other jurisdictions of the physician ~~assistant~~associate;
- E. Issuance of temporary physician ~~assistant~~associate licenses;
- F. ~~Appointment of an advisory committee for continuing review of the physician assistant rules. The physician assistant members of the board must be members of the advisory committee;~~
- G. Continuing education requirements as a precondition to continued licensure or licensure renewal;
- H. Fees for the application for an initial physician ~~assistant~~associate license, which may not exceed \$300; and
- I. Fees for the biennial renewal of a physician ~~assistant~~associate license in an amount not to exceed

\$250.

§XXXX-B. Physician ~~assistant~~associate 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 ~~assistant~~associate under this

chapter. The board shall request a background check for each licensed physician ~~assistant~~associate who applies for an initial compact privilege and designates this State as the applicant's participating state from which the licensee is applying. 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~~associate 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~~associate 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 ~~Assistant Associates~~ 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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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

§XXXX. Full licensure of 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;

B. Graduate from an unaccredited medical school, be evaluated by the Educational Commission for Foreign Medical Graduates and receive a permanent certificate from the Educational Commission for Foreign Graduates; or

C. Graduate from an unaccredited medical school and achieve a passing score on the Visa Qualifying Examination or another comprehensive examination determined by the board to be substantially equivalent to the Visa Qualifying Examination.

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.

3. **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

Commented [TT4]: THE LCME stopped accrediting Canadian schools on 6/30/25. We need to discuss how to proceed with Canadian students.

Commented [TT5]: 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.

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.

4. 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.

5. Fees. Each applicant shall pay a fee up to \$600 plus the cost of the qualifying examination or examinations.

6. 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.

7. 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 must be paid 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.

~~**8. 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.~~

§XXX. Full licensure of 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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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. 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.

4. Fees. An applicant must pay a fee up to \$600 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.

5. 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.

~~**6. Special license categories.** The board may issue a license limited to the practice of administrative medicine, or any other special license, as set forth by routine technical rule of the board adopted pursuant to Title 5, chapter 375, subchapter 2-A.~~

§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. 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. 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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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. 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. The fee for this license may be not more than \$300.

6. 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.

7. Contract students. An applicant who is qualified under section XXXX who received a medical education as a contract student as provided in Title 20-A, chapter 421, and who agrees to practice in a primary care or other specialized area as defined in Title 20-A, section 11803, subsection 2, or an underserved area as defined in Title 20-A, section 11802, is considered to have completed the postgraduate training requirements of section XXXX, subsection XXXX, upon satisfactory completion of at least 12 months in a graduate educational program approved as specified in section XXXX. The board may make the relicensure of an individual for 4 years after the individual's licensure under this subsection contingent on the individual's continuing to practice in an underserved area. This subsection applies only to individuals entering into a contract under Title 20-A, chapter 421, on or before December 31, 1984. The fee for this license may be not more than \$300.

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

1. Renewal of full licenses. A physician of physician ~~assistant~~associate with a full license issued by the board 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 full license renewal that is valid for no longer than 2 years.

A. Beginning with licenses expiring after July 1, 1994, regardless of the date of initial licensure or last license renewal, the license of every physician and physician ~~assistant~~associate born in an odd-numbered year expires at midnight in 1995 on the last day of the month of the individual's birth. The license of every physician and physician ~~assistant~~associate born in an even-numbered year expires at midnight in 1996 on the last day of the month of the individual's birth. Upon expiration, a physician or physician ~~assistant~~associate must renew the license issued pursuant to this section and this license must be renewed every 2 years by the last day of the month of birth of the individual

seeking license renewal 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 full 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 full license may be reinstated within 90 days after the date of expiration upon 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 full license, the license immediately and automatically lapses. The board may reinstate a full license that has lapsed pursuant to subsection 4.

2. Criteria for full 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 full license with the intent of conducting active medical practice 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 practice of medicine in this State in any degree, including advising or prescribing medication for self, friends or family with or without charge, 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 \$500 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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

4. Reinstatement after lapse. A full 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 full 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 full 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 practice of medicine continuously for at least the past 12 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 competency by passage of written examinations or practical demonstrations as the board may from time to time prescribe for this purpose through rulemaking.

§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.

§XXXX. Inactive license status

A licensee who wants to retain licensure while not practicing may apply for an inactive status license. During inactive status, the licensee must renew the license and pay the renewal fee set by rule

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 composition of investigative committees are subject to the following. An investigation committee must contain, if possible:

A. If the investigation involves allegations against an allopathic physician: Two allopathic physicians, one osteopathic physician, one physician ~~assistant~~associate, and one public member.

B. If the investigation involves allegations against an osteopathic physician: Two osteopathic physicians, one allopathic physician, one physician ~~assistant~~associate, and one public member.

C. If the investigation involves allegations against a physician ~~assistant~~associate: Three physician ~~assistant~~associates, one physician, and one public member.

2. **Powers and duties of an investigative committee.** An investigative committee of the board has the following powers and duties:

Commented [TT6]: There was discussion about the size and composition but nothing definitive was determined

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

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. Failure to comply with a direction of the committee to submit to a mental or physical examination results in the immediate suspension of the license of the individual until the individual submits to the examination.

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. Consent agreements may be entered into only with the consent of the applicant or licensee, the 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 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.

3. Adjudicatory hearings. 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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

§XXXX. Complaints; reports; investigations

1. 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. 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 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 by an individual who is not licensed under this chapter 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:
 - (1) 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
 - (2) 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 that has been established in the practice for which the licensee is licensed or authorized by the board;

Commented [TT7]: Is this phrase necessary?

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 narcotic or hypnotic or other drugs listed as controlled substances by the Drug Enforcement Administration for other than accepted therapeutic purposes;

K. Failure to report to the board a physician licensed under this chapter for addiction to alcohol or drugs or for mental illness in accordance with Title 24, section 2505, except when the impaired physician is or has been a patient of the licensee or the physician has been referred to the Medical Professionals Health Program;

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 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. 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;

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

P. 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;

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

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

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

2. Judicial review. Notwithstanding any provision of Title 10, section 8003, subsection 5-A to the contrary, any nonconsensual revocation pursuant to Title 10, section 8003, subsection 5-A 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-A, 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 ~~assistant~~associates

A physician or physician ~~assistant~~associate may delegate to the physician's or physician ~~assistant~~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 ~~assistant~~associate; the activities being delegated do not, unless otherwise provided by law, require a license, registration or certification to perform; the physician or physician ~~assistant~~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 ~~assistant~~associate ensures that the employees or support staff perform these delegated activities competently and safely. The physician or physician ~~assistant~~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 ~~assistant~~associate's agent. This section may not be construed to apply to registered nurses acting pursuant to Chapter 31 or physician ~~assistant~~associate acting pursuant to this chapter.

§XXXX Physician ~~assistant~~associates; scope of practice and agreement requirements

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

- A. "Collaborative agreement" means a document agreed to by a physician ~~assistant~~associate and a physician that describes the scope of practice for the physician ~~assistant~~associate 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.
- B. "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.
- C. "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~~associate, advanced practice nurse, nurse, physical therapist, occupational therapist, speech therapist, social worker, nutritionist, psychotherapist, counselor or other licensed professional.
- D. "Physician" means a person licensed by the board.
- E. "Physician ~~assistant~~associate" means a person licensed by the board. .
- F. "Practice agreement" means a document agreed to by a physician ~~assistant~~associate who is the principal clinical provider in a practice and a physician that states the physician will be available to the physician ~~assistant~~associate for collaboration or consultation.
- G. "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 under the federal Controlled Substances Act, 21 United States Code, Section 812.

2. Scope of practice. A physician ~~assistant~~associate may provide any medical service for which the physician ~~assistant~~associate has been prepared by education, training and experience and is competent to perform. The scope of practice of a physician ~~assistant~~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.

3. Dispensing drugs. Except for distributing a professional sample of a prescription or legend drug, a physician ~~assistant~~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.

4. Consultation. A physician ~~assistant~~associate shall, as indicated by a patient's condition, the education, competencies and experience of the physician ~~assistant~~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 ~~assistant~~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.

5. Collaborative agreement requirements. A physician ~~assistant~~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 ~~assistant~~associate's scope of practice, except that a physician ~~assistant~~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 ~~assistant~~associate is legally responsible and assumes legal liability for any medical service provided by the physician ~~assistant~~associate in accordance with the physician ~~assistant~~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 ~~assistant~~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 ~~assistant~~associate is no longer subject to the requirements of this subsection.

6. Practice agreement requirements. A physician ~~assistant~~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 ~~assistant~~associate has a practice agreement with an active physician, and other health care professionals as necessary, that describes the physician ~~assistant~~associate's scope of practice. A physician ~~assistant~~associate is legally responsible and assumes legal liability for any medical service provided by the physician ~~assistant~~associate in accordance with the physician ~~assistant~~associate's scope of practice under subsection 2 and a practice agreement under this subsection. A physician ~~assistant~~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 ~~assistant~~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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

physician ~~assistant~~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.

7. 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 ~~assistant~~associates, this section must be liberally construed to authorize physician ~~assistant~~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 ~~assistant~~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 ~~assistant~~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

An allopathic physician licensed pursuant to chapter 48, an osteopathic physician licensed pursuant to chapter 36, 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 Commissioners of the Profession 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.

DRAFT STATUTE FOR COMBINED MEDICAL 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. On or after January 1, 2017, 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. On or after January 1, 2017, 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 as a condition of prescribing 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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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 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 ~~assistant~~associates in Maine:

1. The Maine Board of Medicine is created and established by law. All references to, responsibilities of and authority conferred upon the 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 ~~assistant~~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.



THE NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS

101 West Elm Street, Suite 230
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866-479-6828

8765 West Higgins Road,
Suite 200, Chicago, IL 60631

TO: Maine BOLIM/BOL Workgroup

FROM: National Board of Osteopathic Medical Examiners

DATE: September 9, 2025

SUBJECT: Proposed Merger of BOLIM and BOL and Support for Separate Boards

The National Board of Osteopathic Medical Examiners (NBOME) **writes to express our support for enhancing the resources for the separate and distinct Maine Board of Osteopathic Licensure (BOL) to serve a key role in professional self-regulation for the practice of osteopathic medicine in support of the care of patients in the state of Maine.** We believe the patients and the profession are best served by a separate and distinct osteopathic medical board in Maine, as well as a separate and distinct Maine Board of Licensure in Medicine (BOLIM), without merging the two together as a single Board.

The NBOME, a 501(c)(3) nonprofit organization founded in 1934, has a mission to protect the public by providing the means to assess competencies for osteopathic medicine and related health care professions. The NBOME's COMLEX-USA examination is recognized and accepted for licensure purposes by all U.S. medical and osteopathic medical licensing boards and in other countries around the world. We appreciate your recognition that COMLEX-USA evaluates the competencies required for delivering safe and high quality osteopathic medical care to patients. We stand along with the American Osteopathic Association (AOA), the AOA-Commission on Osteopathic College Accreditation (AOA-COCA), the American Society of Osteopathic Medical Regulators (ASOMR), and now the Accreditation Council for Graduate Medical Education (ACGME) in working with the nation's state licensing boards in stewarding professional self-regulation for the osteopathic medical profession and continuing to earn the trust of the patients we serve. We stand alongside the stellar University of New England College of Osteopathic Medicine (UNECOM) in Maine (where I served as Dean and Vice President for Health Services 2007-2009), the only osteopathic medical school in New England and the only DO or MD-granting school in Maine, in credentialing DOs who serve throughout the state since 1978. The osteopathic model continues to expand in the United States in part due to this trust and the current system that generates compassionate, committed and competent physicians who disproportionately care for patients in many of our nation's rural and underserved communities and specialties of need, including in Maine. With now about 200,000 total practicing DOs, residents and students, of the top six states in number of practicing DOs, four of these are states that entrust separate and distinct osteopathic medical licensing boards with the important responsibility in professional self-regulation, licensure and discipline in these states. Now over 25% of all medical students in the United States are choosing to attend a DO-granting school.

Thank you again for allowing us to listen in to deliberation of the "Board of Licensure in Medicine/Board of Osteopathic Licensure Workgroup" virtual meeting on August 27, 2025, led by



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BOLIM Executive Director, Timothy Terranova. In listening to the deliberations of the workgroup and reviewing the meeting materials provided, it became even more clear that having a separate and distinct BOLIM and BOL remains critical in protecting the public and positioning the state for responsiveness to projections for further physician shortages particularly in rural and other underserved areas in Maine. Maintaining two distinct boards would further protect the public by allowing the BOLIM to focus on likely challenges that may emerge in the near future, including the extensive work cited by Mr. Terranova that is required each year by BOLIM staff related to the licensure of international medical graduates (i.e., for IMGs-MDs) who complete postgraduate training accredited by “the Canadian Medical Association, the Royal College of Physicians of Canada or the Royal Colleges of England, Ireland or Scotland”. This was described by Mr. Terranova as “time-intensive work we have done for decades.” Now with the 2025 change of the Liaison Committee on Medical Education (LCME) no longer accrediting Canadian MD-granting schools and should the Maine legislature approve pending Maine House Bill 105 which would create a temporary license for IMGs, it is likely that the work of the Maine BOLIM will escalate significantly due to these changes in the upcoming years. As outlined by the authoritative “Advisory Commission on Additional Licensing Models (August 2025)” (see link below), recommended requirements and responsibilities of state medical boards for internationally trained physicians (ITPs) include extensive needs for assessment, supervision, communication, reporting, and verification to help the board in protecting the public. For osteopathic medicine and DOs and the BOL, there is only one osteopathic medical school accreditation authority (AOA-COCA), and one licensing examination (COMLEX-USA) and one GME accreditor (ACGME). It would make sense to an observer that it is unwise to encumber the BOL and osteopathic physicians with the escalating challenges faced by the BOLIM, including those that are unique to the BOLIM and not relevant to the BOL. This would seem to be another very good reason to support two separate and distinct boards at this time, and why the public of Maine and the legislature should support a solution that ensures that both boards are well resourced to fulfill their respective professional self-regulation responsibilities.

Finally, as the BOL appears to be financially self-sustaining from physician licensure fees and also appears to have funding for additional staff that has not yet been resourced for that purpose, there would be no benefit to the state or taxpayers from merging the two separate and distinct boards into a single board with divergent responsibilities. On the contrary, eliminating the BOL and the BOLIM and creating a new board would necessarily involve new administrative and training costs, as already discussed in the proposals, and will likely disrupt the efficient service that the BOL currently provides to Maine DOs, for the benefit of patients. Additional costs incurred due to the complexities of monitoring of IMGs and ITPs in the future will be more efficiently managed by a separate BOLIM, not complicating professional self-regulation or DOs. While the BOL may be currently understaffed, adding some additional staff to the BOL and contracting between boards for select services (as done in numerous states) appears to be a more economically efficient approach rather than consolidating the boards. From the financial models presented during the meeting, it was not clear that there would be any cost efficiencies to creating a single board, and that is what numerous other states who have evaluated such mergers have determined in their deliberations, determining that the best



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course of action for the patients in their states was two strong, separate and distinct boards focused on what they each need to do for patients in their states.

For these reasons, the NBOME supports your collective and sincere efforts focused on protecting the public and considering what is best for them and for access to care throughout your great state. We believe that a strong, separate and distinct board for DOs, working collaboratively with a strong, separate, distinct board for MDs (MBBS, MCh and other international designations for MDs) is the solution that is in the best interests of the patients in Maine. We hope that the workgroup comes to this conclusion as does the BOLIM and the BOL and that the two boards and the workgroup provide the Maine legislature with a unified vision and recommendation for two strong boards, the BOM and the BOLIM. This, in our view, would be a victory for defensible and just professional self-regulation for both professions and related health care professions and the patients we have the privilege to serve.

Sincerely,

John R. Gimpel, DO, MEd
President & CEO

References:

[Advisory Commission on Additional Licensing Models](#) (August 2025)

Cc: Kathryn Brandt, DO, MS, MEdL, MOA, President
Jane E. Carreiro, DO, UNECOM, Dean & VP, Health Affairs
Kathleen S. Creason, MBA, AOA, Chief Executive Officer
Amanda Mahan, MOA, Executive Director
Raine Richards, JD, ASOMR VP, State & International Affairs

TO: Maine Board of Licensure in Medicine/Board of Osteopathic Licensure Workgroup

FROM: American Osteopathic Association
Maine Osteopathic Association

DATE: September 7, 2025

SUBJECT: August 27, 2025 Workgroup Meeting

The American Osteopathic Association (AOA) and the Maine Osteopathic Association (MOA) write to thank the Maine Board of Licensure in Medicine (BOLIM) and the Maine Board of Osteopathic Licensure (BOL) Workgroup (the “Workgroup”) for considering our comments during recent meetings, while reiterating our ongoing concerns regarding a potential merger of the BOLIM and the BOL. It is our belief that the Workgroup has supported a merger since its inception, and the budgetary analysis to maintain a separate BOL that was produced in advance of the Workgroup’s eighth meeting exceeds the staffing needs expressed by the BOL, with the goal of bolstering the rationale for a merger. We urge the Workgroup in its final meetings to give equal weight and consideration to the option of maintaining separate boards, which the AOA and the MOA believe is in the best interest of physicians and patients in Maine.

The AOA represents more than 197,000 osteopathic physicians (DOs) and osteopathic medical students (OMSs) nationwide. The AOA promotes public health, encourages scientific research and serves as the primary certifying body for DOs. The MOA is a professional medical organization representing more than 2,000 licensed DOs and over 700 OMSs currently attending the University of New England College of Osteopathic Medicine – the state’s only medical school – in Biddeford, Maine.

The AOA and the MOA strongly believe that maintaining separate licensing boards benefits the state of Maine – and should be given full consideration – for the following reasons:

- While DOs and MDs complete the same basic training, DOs **additionally** receive **several hundred hours of training** that MDs traditionally do not receive, **in osteopathic principles and practice**, which allows them to provide hands-on treatment to their patients (osteopathic manipulative treatment or OMT) and approach their care from a holistic perspective that takes into account body, mind and spirit. The approach also focuses on the body’s ability to restore itself to wellness.
- The unique osteopathic philosophy is woven throughout osteopathic medical education and training, and osteopathic competencies are assessed via the DO licensing exam series, the Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA).
- Many students choose to pursue a career in osteopathic medicine specifically for the additional training and unique approach to care that allows them to partner with their patients to achieve sustainable, long-term wellness, encompassing both their physical and mental health. OMT has been shown to help patients with a variety of complex conditions, including chronic low back pain, alleviating the need for riskier pharmacologic interventions such as opioids.¹ For these reasons, **DOs tend to pursue careers in primary care specialties and in rural and underserved urban areas at higher rates than MDs,**² which holds particular benefits for a

¹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7381089/>

² <https://osteopathic.org/index.php?aam-media=wp-content/uploads/2024-OMP-Report.pdf>

state like Maine, where 11 of its 16 counties are designated as Healthcare Professional Shortage Areas or Medically Underserved Areas, affecting 40% of the state's population.³

- The BOL has been efficiently serving DOs and their patients in the State of Maine for over 100 years, as evidenced by the fact that the Board is **entirely self-sustaining** through application fees and fines, and does not require any money from the state to operate. In addition, as part of its licensing process, the BOL personally reviews each application to ensure the highest standards of patient care and professionalism—whereas the MD board typically allows staff to approve most applications unless there are specific concerns requiring further review.
 - It is unclear which process a combined board would follow, but the aforementioned differences could account for some differences in staff workload between the two boards.
 - Regardless, we urge the Workgroup to consider an alternative budget analysis that reflects the BOL's true staffing needs of 1.5 full time employees, according to information that we received from the BOL.

Our organizations urge you to celebrate and support the unique contributions DOs bring to the health and well-being of Maine's patients, who benefit from the whole-person and hands-on approach to care that DOs specialize in. The Maine BOL is uniquely positioned to assess osteopathic competencies, and take disciplinary action where needed, and has been efficiently and effectively serving Maine for years. Therefore, we ask that you please continue to support the freedom of osteopathic physicians to regulate their distinct profession.

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 richards@osteopathic.org or Amanda Mahan, MOA Executive Director, at amahan@mainedo.org.

Sincerely,



Robert Piccinini, DO, D.FACN
President, AOA



Kathryn Brandt, DO
President, MOA

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
Amanda Mahan, Executive Director, MOA

³ <https://www.maine.gov/dhhs/mecdc/public-health-systems/rhpc/rural-health.shtml>

Board of Licensure in Medicine - Board of Osteopathic Licensure
Workgroup
ZOOM meeting
October 22, 2025
5:30 p.m. – 7:22 p.m.

Board Members Present

Lisa Ryan, DO (BOL)
Public Member Dennis Smith, Esq. (BOL)
Public Member Peter Michaud, JD, RN (BOL)
John Brewer, DO (BOL)
Paul Vinsel, DO (BOL)
Public Member Mary-Anne Ponti, RN, DBA (BOL)
Christine Munroe, DO (BOL)
Public Member Lynne Weinstein (BOLIM)
Anthony Ng, MD (BOLIM)
Noah Nesin, MD (BOLIM) (excused at 6:35 p.m.)

Board Staff Present

Executive Secretary Rachel MacArthur (BOL)
Executive Director Timothy Terranova (BOLIM)
Assistant Executive Director Valerie Hunt (BOLIM)
Administrative Assistant Maureen Lathrop (BOLIM)
Medical Director Paul Smith, MD (BOLIM)

Legal Counsel Present

Assistant Attorney General Lisa Wilson (BOL)

A roll call of board members present was conducted.

Review of the FAQ Document

The workgroup reviewed the FAQ documents and had no comments.

Review of Possible Advantages/Disadvantages Document

The workgroup reviewed the possible advantages/disadvantages document prepared by Board staff. Ms. Ponti inquired if BOLIM members use or have access to a portal for document sharing. Mr. Terranova responded that BOLIM members use MOVEit and FileZilla to access and download documents. AAG Wilson noted that BOLIM members also have state-issued laptops for Board business while BOL members do not.

Workgroup members agreed that accessing and downloading documents through a secure portal and having state-issued laptops for Board business should be included as advantages.

Mr. Smith stated that another advantage to merging the Boards would be having an Executive Director. He noted that the Maine BOL is the only osteopathic board that does not have an executive director or management level administrator. He stated that the Executive Director performs many vital functions for the Board including dealing with the legislature and drafting and revising Board rules.

Review of the draft budget numbers for the Board of Osteopathic Licensure

No updated budget numbers were available. The workgroup briefly discussed that BOL recently received approval for one additional staff member. Mr. Michaud requested that board issued laptops be included in any future budget analysis

Review of Licensing Trends

The workgroup discussed statistics provided by the FSMB. Ms. Ponti noted that there are many variables besides board merger that factor in changes in licensure numbers. Mr. Michaud added that when states joined the IMLC may also affect numbers, and no conclusion could be drawn from the information. Mr. Michaud also inquired if there were any boards that had separated into separate allopathic and osteopathic boards. Staff were not aware of any and noted that the trend is consolidation.

Review of Proposed Statute – BOLIM Staff side by side review edits

BOLIM staff made a side-by-side comparison of current and proposed statutes. BOLIM reviewed the comparison at its October meeting. In the definition section – MD and PA definitions were consolidated into one section. The practice of medicine definition is slightly different than current statute. Mr. Smith noted that the definition in the draft statute was taken from the FSMB Model Practice Act. The use of the term physicians and surgeons apply only to MDs and DOs.

There was a concern under penalties regarding inconsistency with Title 10 § 8003-C. The AG's office can advise the Boards.

Mr. Terranova noted that in past workgroup discussions the workgroup liked the Kentucky model which splits the Board into two evenly split committees.

Dr. Nesin noted a concern about maintaining consistency in approach so that cases of equivalent circumstances are handled the same. For example, if one committee issues a letter of guidance and the other committee dismisses without any action that would be viewed as unfair. Mr. Terranova noted that some Boards use rubrics.

Dr. Nesin also expressed concern about specialty representation. How will that be accounted for when the cases are assigned to one committee or the other? Mr. Terranova responded that cases may be assigned to the committee with the appropriate specialty. Dr. Nesin stated that his opinion is that this will be a complex transition and maintaining the current structure of the Board as a whole rather than two evenly split committees would simplify things.

Mr. Smith agreed that Dr. Nesin's concern is valid but noted that if both committees are staffed with an AAG to provide guidance that will assist the committees in being consistent in their decision-making processes.

Mr. Michaud noted that there will be complaints that similar cases are treated differently by different committees. No two cases are identical; there are always differences.

Mr. Michaud stated that the workgroup has discussed equal representation for the three professions, but this structure dilutes the public members. The workgroup may need to consider increasing the number

of public members.

Mr. Terranova noted that BOLIM recommended removing term limits for Board members. Mr. Smith said that any changes to term limits would need to be coordinated with the Governor's Office who appoints members to the Boards.

Mr. Terranova reminded the workgroup that Dr. Vinsel drafted a preamble for legislation that was provided for review. Workgroup members agreed that the language was well-stated and concise. Mr. Michaud noted that it is essential that the statute includes the language from the preamble.

Following discussion, the consensus of the workgroup was to model the structure after the Kentucky model to divide the Board into two evenly split committees for complaint review and adjudicatory hearings. The workgroup further agreed that the composition of the Board should be 6 allopathic physicians, 6 osteopathic physicians, 4 physician associates and 4 public members.

The workgroup took a straw poll to determine what the workgroup members would recommend to their respective Boards regarding potential merger. Of the 7 members present during the poll, 6 would recommend that the Boards proceed with merger and 1 abstained.

Next Steps

Provide a clean copy of the statute for review.

Prepare a one-page summary of the statute with changes and a list of remaining points to be discussed.

Prepare a combined document of all the workgroup discussions for the review of each Board

Public Comment

Teresa Hubka, DO – Dr. Hubka thanked workgroup members for all the work they have done. Dr. Hubka is an OB/Gyn in Chicago, IL and the immediate past president of the AOA. She has reviewed all the materials. In hearing some of the comments, she understands that there are struggles with finances. The most important thing about not merging is protecting the public and recognizing the distinction of osteopathic training. She stated that all physicians strive to practice evidence-based medicine, but there are distinct differences in how they practice medicine. She noted that the BOL recently received approval for an additional staff person to assist with needs. Dr. Hubka stated that BOLIM spends a significant amount of time licensing international medical graduates. IMGs are unique to BOLIM and not relevant to BOL. She also noted that osteopathic physicians take care of patients in rural and underserved areas of Maine.

John Diefenderfer, DO – Dr. Diefenderfer thanked workgroup members for listening to public comments. He indicated that he was sorry to hear that some workgroup members expressed feeling that they have targets on their backs for expressing their opinions. He noted that change is difficult and there is a lot of change in healthcare right now. Hospitals are struggling financially and otherwise. He acknowledged that change may be needed, but merging the Boards may not be the right change. Sometimes merging is more efficient and sometimes it leads to increased administrative burdens. He agrees working together is the best way forward.

Josie Conte, DO – Dr. Conte is the president-elect of the MOA. Dr. Conte expressed that she appreciates how things have evolved over the last few months. She can understand the struggles and appreciates the

transparency of the workgroup. Dr. Conte was glad to hear that osteopathic physicians would have equal representation on a merged Board. She was concerned that the membership would be determined by percentages of allopathic and osteopathic physicians. She appreciates the recognition of osteopathic medicine as distinct. Dr. Conte thanked the workgroup members for their work.

Written Comments Received

All written comments have been shared with the workgroup.

Next meeting is November 19th at 5:30 p.m.

Adjourn 7:22 p.m.

Preamble to Draft Legislation Combining Licensing Boards
For Allopathic Physicians, Osteopathic Physicians, and Physician Associates

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.

Directory of State Licensing Boards for Doctors of Osteopathic Medicine

Medical Doctor (M.D.) Licensed Boards by State

Some states regulate Doctors of Osteopathic Medicine (D.O.) via a separate regulatory agency. This is a list of those states.

Click here for a link of M.D. regulatory agencies.

State

Contact (if separate DO agency)

Alabama

Alaska

Arizona Board of Osteopathic Examiners in Medicine in Surgery

Arizona

Rachel Shepherd, Interim Executive Director
9535 East Doubletree Ranch Road
Scottsdale, AZ 85258-5539
(480) 657-7703 / Fax (480) 657-7715
www.azdo.gov

Arkansas

Osteopathic Medical Board of California

California

Angelina M. Burton, Executive Director
1300 National Drive, Suite 150
Sacramento, CA 95834-1991
(916) 928-8390 / Fax:(916) 928-8392
www.ombc.ca.gov/

Colorado

Connecticut

Delaware

District of Columbia

Florida Board of Osteopathic Medicine

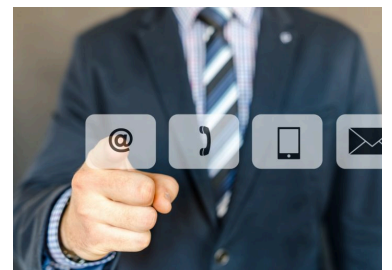
Florida

Kama Monroe, JD Executive Director
4052 Bald Cypress Way, #C-06
Tallahassee, FL 32399-3256
(850) 245-4161 / Fax:(850) 921-6184
www.floridasosteopathicmedicine.gov

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Georgia
Hawaii
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Louisiana

Maine Board of Osteopathic Licensure

Maine
Susan E. Strout, Executive Secretary
142 State House Station
Augusta, ME 04333-0142
(207) 287-2480 (207) 287-3015
www.maine.gov/osteo/

Maryland

Michigan Board of Osteopathic Medicine and Surgery

Michigan
Cheryl W. Pezon, JD, Executive Director
P.O. Box 30670
Lansing, MI 48909-8170
(street address: 611 W. Ottawa St, 1st floor, 48933)
(517) 335-1001 / Fax:(517) 373-2179
www.michigan.gov/healthlicense

Massachusetts
Mississippi
Minnesota
Missouri
Montana
Nebraska
New Hampshire

Nevada State Board of Osteopathic Medicine

Nevada
Sandy Reed, Executive Director
2275 Corporate Circle, Suite 210
Henderson, NV 89074
(702) 732-2147 / Fax:(702) 732-2079
www.bom.nv.gov

New Jersey
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New Mexico Board of Osteopathic Medical Examiners

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Roberta Perea, Executive Director
P.O. Box 25101
Santa Fe, NM 87501
(505) 476-4629 / Fax:(505) 476-4665
www.rld.state.nm.us/boards/Osteopathy.aspx

North Carolina

New York

North Dakota

Oklahoma State Board of Osteopathic Examiners

Oklahoma

Deborah J. Bruce, JD, CMBE, Executive Director
4848 N. Lincoln Blvd., Suite 100
Oklahoma City, OK 73105-3321
(405) 528-8625 / Fax:(405) 557-0653
www.ok.gov/osboe/

Ohio

Oregon

Pennsylvania State Board of Osteopathic Medicine

Pennsylvania

Aaron Hollinger, Administrator
P.O. Box 2649
Harrisburg, PA 17105-2649
(street address: 124 Pine St., 17101)
(717) 783-4858 / Fax:(717) 787-7769
www.dos.state.pa.us

Puerto Rico

South Dakota

South Carolina

Tennessee

Texas

Vermont Board of Osteopathic Physicians and Surgeons

Vermont

Office of Professional Regulation
89 Main Street, 3rd Floor
Montpelier, VT 05620-3402
802-828-1502 / Fax: (802) 828-2465
www.sec.state.vt.us/

Utah

Utah Osteopathic Physicians & Surgeons Licensing Board

Larry Marx, Bureau Manager
PO Box 146741
Salt Lake City, UT 84114-6741

(801) 530-6628 / Fax:(801) 530-6511
www.dopl.utah.gov

Virginia

Washington Board of Osteopathic Medicine and Surgery

Washington

Blake T. Maresh, MPA, CMBE, Executive Director
Department of Health
P.O. Box 47852
Olympia, WA 98504-7852
(360) 236-4700 / Fax:(360) 236-4818
www.doh.wa.gov

West Virginia Board of Osteopathic Medicine

West Virginia

Diana K. Shepard, CMBE, Executive Director
405 Capitol Street, Suite 402
Charleston, WV 25301
(304) 558-6095 / Fax:(304) 558-6096
www.wvbdosteo.org

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Board of Licensure in Medicine/Board of Osteopathic Licensure Workgroup
161 Capitol Street
Augusta, Maine 04333-0137
October 22, 2025
5:30 pm

The October 22, 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/84678747985>

Meeting ID: 846 7874 7985 Passcode: 55407552 or by phone (312) 626-6799 or 1 (646) 876-9923

-
- I. Role Call of Board Members
 - II. Review of the FAQ Document
 - III. Review of Possible Advantages/Disadvantages Document
 - IV. Review of the draft budget numbers for the Board of Osteopathic Licensure
 - V. Review of Licensing Trends
 - VI. Review of Proposed Statute – BOLIM Staff side by side review edits
 - VII. Next Steps
 - VIII. Public Comment
 - A. Written Comments Received
 - IX. Adjourn

Board of Licensure in Medicine & Board of Osteopathic Licensure

Question & Answer

Are MD's and DO's currently licensed by separate boards?
➤ Yes, The Board of Osteopathic Licensure (BOL) licenses osteopathic physicians and physician assistants. The Board of Licensure in Medicine (BOLIM) licenses allopathic physicians and physician assistants. Maine is one of twelve (12) states that has separate boards.
Why are there two licensing boards?
➤ BOLIM began licensing allopathic physicians in 1895. When osteopathic physicians requested licensure from the state, they were given a separate board, BOL, in recognition of their focus on osteopathic medicine, including osteopathic manipulation.
What are other states doing?
➤ Boards have changed over time with a high of 30 states having separate boards in 1939. Today only 12 states have separate medical and osteopathic boards. Three states have consolidated medical and osteopathic boards since 2021. (Data provided by the Federation of State Medical Boards)
What has changed?
➤ MDs, DOs and PAs work side by side in a collaborative manner every day. The post graduate training for MDs and DOs are accredited by the same organization, and DOs and MDs can be found in every specialty. With the exception that DOs have additional training in osteopathic ideals, the education, training and examination requirements are similar.
What are the missions of the boards?
➤ The mission of both boards is the same: Protect the health, safety and welfare of Maine citizens.

Do the boards currently collaborate?
➤ Yes, the boards currently have 5 joint rules and share one staff person.
Why are the boards considering merging?
➤ There are several reasons for a proposed merger of the two boards. BOL has one (1) full-time employee that is responsible for all aspects of board functions, including administrative, legislative, licensing and investigative. BOLIM has ten (10) full-time employees. BOLIM currently reviews approximately 30 complaints and investigations each month. BOL sees a quarter to a third of that number each month. Merging would allow the work to be distributed among more members and may also allow for more efficient processing of licensing, complaints, investigations and hearings. There is a growing recognition in the profession that health care is delivered in a collaborative team setting. Merging would reflect the current realities of practice by placing three members of the collaborative health care team under one board. Although not yet determined, the boards are also looking to see what financial impact a merger would have.
Can MDs judge complaints against DOs and vice versa?
➤ Currently, DOs, PAs and public members evaluate and adjudicate complaints against DOs. Likewise, MDs, PAs and public members evaluate and adjudicate complaints against MDs. When there is a question of practice that is outside of the specialty of board members, the case is referred to an outside expert in the field for review, which board members then use to make a determination on the outcome of the case.
What would representation look like on a merged board?
➤ Although the boards have not settled on firm numbers, they are still studying the feasibility, they have agreed in principle that equal representation for DOs and MDs is required and that consistent proportional representation for PAs and public members is also required.
How can I find more information?
➤ More information and updates can be found on the boards' websites, www.maine.gov/osteo and www.maine.gov/md.

How can I provide input?

- The boards have created a workgroup that meets once a month. There will be time for public comment at those meetings. In addition, you can email questions and comments to board staff at tim.e.terrano@maine.gov and rachel.macarthur@maine.gov. Please copy both on any correspondence.

Board of Licensure in Medicine & Board of Osteopathic Licensure

This is a general list created for discussion purposes only. The workgroup will need to discuss how the information provided might impact public safety.

Possible Advantages	Possible Disadvantages
As drafted the proposed statute recognizes that the three healthcare professions have their own education and values. It ensures that the individual education and values are preserved.	Perception of a loss of identity for all three health care professions
Administrative	Administrative
- Shared resources - Staff - Financial - Board work - Streamlining of functions - Invoices - Contracts, supplies - Payroll - Budget - Rulemaking - One contact point for licenses, public, and other entities (hospitals, etc.) - Avoid office closure for time off/vacation - PAs licensed by only one board	- Current work brought from each Board – as of 10/10/25 - BOLIM Adjudicatory Hearings - 2 (1 in progress and 1 ordered) - BOLIM Open Complaints - 126 - BOLIM Open Investigations (ADs) - 27 - BOL Adjudicatory Hearings - 4 pending - BOL Open Complaints - 46 - BOL Open Investigations - 6 - Larger board could be seen as more bureaucratic - Possible confusion from licensees during the transition
Financial	Financial
- Costs are distributed to a larger pool of licensees - Streamlining of functions should see some savings over time	- Initial increase in cost to fund transition (funds can be taken from savings if approved/appropriated) - Fees are currently different and there would need to be some type of standardization
Standard Practices	Standard Practices
Licensees will have consistent administrative standards and practices	Licensees may need to adapt to standards/rules currently in place with only 1 board

Terranova, Tim E

From: Xiaomei Pei <xpei@fsmb.org>
Sent: Monday, October 6, 2025 3:35 PM
To: Terranova, Tim E; Aaron Young
Cc: Xiaomei Pei
Subject: Re: data request
Attachments: Maine_MD_DO_Licenses_Trends2020_2024.xlsx

EXTERNAL: This email originated from outside of the State of Maine Mail System. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Hi Tim,

Per your request, the attached file shows the results for all licensees and first-time license issued from 2020 to 2024 for Maine, as well as New Mexico, Illinois, Utah and all states, using 2024 FSMB census data. Please take a close look and let us know if you have any questions.

Below is a brief summary of my observations:

- All licensees
 - Across all states, the average annual increase rate for DO licenses issued was 7%, outpacing MD licenses at a 4% annual growth rate.
 - In Maine, both DO and MD licenses saw a significant decline from 2020 to 2021 (DO: -21% vs MD: -26%), possibly due to pandemic impact. DO licenses increased again through 2024.
 - Over the past five years, DO licenses in Maine grew at an average annual rate of 5%, with a steady upward trend since 2021. In contrast, New Mexico DO licenses showed a slight decline since 2022.
- First-time licenses
 - The national average annual increase in first-time licenses was 12% for DOs and 8% for MDs. Smaller volume states saw more year-to-year fluctuations.
 - First-time DO licenses in Maine remained stable over the period, averaging 3% annual growth. Illinois, by comparison, saw the first-time DO licenses decline since 2022.

Note:

- The number of first-time licenses excludes training, temporary, limited and resident licenses whenever they can be identified.
- For all states, the count of all issued licenses includes only one entry per MD or DO per year, even if an individual may have received multiple licenses in that year.

Thanks,

All Licenses Issued by Year

	Maine		New Mexico		Illinois		Utah		All US states	
Year	DO	MD	DO	MD	DO	MD	DO	MD	DO	MD
2020	312	1,580	262	1,218	836	4,914	178	1,102	17,023	89,991
2021	245	1,174	266	1,170	916	4,977	262	1,172	18,340	93,972
2022	318	1,192	348	1,374	969	5,271	290	1,416	20,319	102,117
2023	335	1,258	284	1,629	1,117	5,799	307	1,360	21,642	105,068
2024	355	1,206	279	1,755	1,087	6,050	204	978	22,139	106,099
Total	1,565	6,410	1,439	7,146	4,925	27,011	1,241	6,028	99,463	497,247
Annual Increase % of all licenses by year										
2020 to 2021	-21%	-26%	2%	-4%	10%	1%	47%	6%	8%	4%
2021 to 2022	30%	2%	31%	17%	6%	6%	11%	21%	11%	9%
2022 to 2023	5%	6%	-18%	19%	15%	10%	6%	-4%	7%	3%
2023 to 2024	6%	-4%	-2%	8%	-3%	4%	-34%	-28%	2%	1%
Average annual increase (%)	5%	-6%	3%	10%	7%	5%	8%	-1%	7%	4%

Data source: 2024 FSMB Census Data

First-time licenses issued by Year

	Maine		New Mexico		Illinois		Utah		All US States	
Year	DO	MD	DO	MD	DO	MD	DO	MD	DO	MD
2020	35	68	14	119	198	1,039	28	249	4,337	19,814
2021	36	71	19	107	237	1,034	37	261	5,124	22,351
2022	29	60	18	117	265	1,074	42	282	6,134	26,913
2023	43	85	26	141	251	1,054	35	281	7,026	28,841
2024	35	74	28	111	173	627	31	266	6,722	26,651
Total	178	358	105	595	1,124	4,828	173	1,339	29,343	124,570
Annual Increase % of First-time licenses by year										
2020 to 2021	3%	4%	36%	-10%	20%	0%	32%	5%	18%	13%
2021 to 2022	-19%	-15%	-5%	9%	12%	4%	14%	8%	20%	20%
2022 to 2023	48%	42%	44%	21%	-5%	-2%	-17%	0%	15%	7%
2023 to 2024	-19%	-13%	8%	-21%	-31%	-41%	-11%	-5%	-4%	-8%
Average annual increase (%)	3%	4%	21%	0%	-1%	-10%	4%	2%	12%	8%

Terranova, Tim E

From: Amanda Mahan <amahan@mainedo.org>
Sent: Tuesday, September 30, 2025 3:44 PM
To: Terranova, Tim E
Cc: MacArthur, Rachel; Kathryn Brandt; Wilson, Lisa A; Willis, Jennifer; Charles Soltan
Subject: Re: BOL/BOLIM Feasibility Workgroup 9/24 Meeting

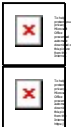
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Tim,

Given the fact that there are no official channels to share such feedback with board leadership or this task force directly, coupled with the recent confusion over deliverance of official correspondence, I thought I would ensure our comments were shared directly. As you will notice, they were also shared with you as staff.

Many Thanks,
Amanda

Amanda Mahan
Executive Director
Maine Osteopathic Association
Phone: [207-623-1101](tel:207-623-1101)
Website: www.mainedo.org



CONFIDENTIALITY NOTICE: This email transmission may contain confidential or legally privileged information that is intended only for the individual or entity named in the email address. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or reliance upon the contents of this email is strictly prohibited. If you have received this e-mail transmission in error, please reply to the sender, so that the Maine Osteopathic Association may arrange for proper delivery, and then please delete the message from your inbox. Thank you.

On Tue, Sep 30, 2025 at 2:28 PM Terranova, Tim E <Tim.E.Terranova@maine.gov> wrote:

Good Afternoon,

Thank you for your email. As you are aware, communications with board members needs to go through the appropriate Board office. Contacting individual Board Members directly is not appropriate.

Please send all future communication to the appropriate Board office.

Thank you

Timothy Terranova

Executive Director

Maine Board of Licensure In Medicine

(207) 287-6930

From: Amanda Mahan <amahan@mainedo.org>

Sent: Tuesday, September 30, 2025 1:26 PM

To: Dr. Christine Munroe <cmunroe@yorkhospital.com>; RFay-LeBlanc@greaterportlandhealth.org

Cc: Terranova, Tim E <Tim.E.Terranova@maine.gov>; MacArthur, Rachel <Rachel.MacArthur@maine.gov>; Kathryn Brandt <kbrandt@une.edu>

Subject: RE: BOL/BOLIM Feasibility Workgroup 9/24 Meeting

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Good Afternoon,

Please see attached for comments from Kat Brandt, DO MOA President following the 9/24 Workgroup meeting.

Dr. Brandt is cced here should you want to reach out for further discussion.

Many Thanks,

Amanda

Amanda Mahan

Executive Director

Maine Osteopathic Association

Phone: [207-623-1101](tel:207-623-1101)

Website: www.mainedo.org



MOA Executive Committee

Kathryn Brandt, D.O.
President

Josephine Conte, D.O.
President-Elect

John Diefenderfer, D.O.
Treasurer

Jodie Hermann, D.O., MBA
Immediate Past President

MOA Board of Directors

Isabella Askari, MPH, D.O.

Lynette Bassett Willard, D.O.

Karen Benezra, D.O.

Jennifer Eaton, D.O.

Breanna Glynn, D.O.

Thomas Pentzer, D.O.

K. Emily Redding, D.O.

Tristan S. Reynolds, D.O.

Mary Yee, D.O.

UNECOM Student Representative
Keely Thomas, OMS-I

Resident Representative
Jacqueline Camm, DO

MOA Staff

Amanda Mahan,
Executive Director

September 29th, 2025

Maine Board of Osteopathic Licensure
Attn: Christine Munroe, D.O. Chair
142 State House Station
Augusta, ME 04333-0142

Maine Board of Licensure in Medicine
Attn: Renee Fay-LeBlanc, MD, Chair
137 State House Station
161 Capitol Street
Augusta, Maine 04333-0137

Dear BOL/BOLIM Feasibility Workgroup Members,

I am writing in response to the meeting Wednesday 9/24 as I was traveling and unable to raise my hand in time during the public comments. I was very heartened by much of the meeting, especially around seeking a budget estimate for an independent osteopathic board more in line with what the BOL staff expressed was needed.

However, towards the end of the meeting it came up that reasoning for merging included that the public did not consider there to be a difference between MDs and DOs and that the "standards of care are the same." While well intended, especially in the context of cooperating around handling issues of pandemic response, this is the crux of why the osteopathic community has been adamant about identity and independence. The standards of care are not the same. There is a difference between MDs and DOs and as Dr Diefenderfer eloquently said, many people seek that difference. Yes, we all strive to practice evidence-based medicine and agree on many things and can and should cooperate. But there is an entire domain of standard of care in osteopathic medicine that does not exist in allopathic medicine. It is within living memory that the allopathic community in Maine did not consider osteopathic physicians to meet the standard of care writ large. It is within recent memory we were shut out of training opportunities, our hospitals usurped and closed.

While the current draft vision of a merged board seeks to respect osteopathic identity, it does not do so in a way that structurally ensures that respect continues in perpetuity. I have observed during these meetings a genuine respect for osteopathic medicine. However, my concern is what happens when and if that sentiment changes?

Thank you for the opportunity to continue the dialogue on this important topic.

Sincerely,

Kathryn Brandt

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

Terranova, Tim E

From: Murray, Douglas <DMurray@nbome.org>
Sent: Thursday, September 25, 2025 8:26 PM
To: Terranova, Tim E; MacArthur, Rachel
Cc: Gimpel, John; Kathleen Creason
Subject: Follow-Up to Maine Workgroup
Attachments: Letter to Maine Board Workgroup 092525.pdf; NBOME Letter to Maine Board Workgroup Sept 2025.pdf

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Mr. Terranova and Ms. MacArthur,

Enclosed please find a letter addressing an issue raised during last night's Workgroup meeting. We are hopeful that the Workgroup will continue to have an open dialogue about the issues raised in both our September 9 letter and the recent letter from the AOA and we look forward to being a part of that discussion. If you have any questions, please let me know.

Best Regards,

Douglas Murray, Esq.
General Counsel
(610) 825-1712





**THE NATIONAL BOARD OF
OSTEOPATHIC MEDICAL EXAMINERS**

101 West Elm Street, Suite 230
Conshohocken, PA 19428

866-479-6828

8765 West Higgins Road,
Suite 200, Chicago, IL 60631

September 25, 2025

Timothy Terranova
Maine Board of Licensure in Medicine

Rachel MacArthur
Maine Board of Osteopathic Licensure

RE: Letter to Maine Workgroup

Dear Mr. Terranova and Ms. MacArthur:

I am writing to follow up on a matter discussed at the Maine Workgroup during its meeting last evening, which I attended virtually. As you both are likely aware, the NBOME sent a letter to the Workgroup recently providing support for the continuation of separate and independent medical boards in Maine. While we were pleased that the Workgroup included the letter in its meeting materials, we were disappointed that there was no discussion of the content of either NBOME or the AOA's letters during the meeting.

Additionally, Mr. Terranova made a statement that the NBOME was confused about which Board it was communicating to and sent its letter to the wrong board. This is incorrect, the letter which we have attached again was addressed to the Workgroup but as there is no dedicated email or other contact information for the Workgroup, it was sent to you both as the staff leads for each organization, as instructed in the FAQ document found on the on the Workgroup page on the BOLIM website. The language from the Workgroup FAQ document is below:

The boards have created a workgroup that meets once a month. There will be time for public comment at those meetings. In addition, you can email questions and comments to board staff at tim.e.terranova@maine.gov and rachel.macarthur@maine.gov. Please copy both on any correspondence.

We appreciate the efforts of the Workgroup to find a solution that will best serve the citizens and patients in Maine and we remain open and available to discuss the issues raised in our letter.

Sincerely,

Douglas Murray

Douglas Murray, Esq,
General Counsel

cc: John R. Gimpel, DO, MEd
Kathleen Creason



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8765 West Higgins Road,
Suite 200, Chicago, IL 60631

TO: Maine BOLIM/BOL Workgroup

FROM: National Board of Osteopathic Medical Examiners

DATE: September 9, 2025

SUBJECT: Proposed Merger of BOLIM and BOL and Support for Separate Boards

The National Board of Osteopathic Medical Examiners (NBOME) **writes to express our support for enhancing the resources for the separate and distinct Maine Board of Osteopathic Licensure (BOL) to serve a key role in professional self-regulation for the practice of osteopathic medicine in support of the care of patients in the state of Maine.** We believe the patients and the profession are best served by a separate and distinct osteopathic medical board in Maine, as well as a separate and distinct Maine Board of Licensure in Medicine (BOLIM), without merging the two together as a single Board.

The NBOME, a 501(c)(3) nonprofit organization founded in 1934, has a mission to protect the public by providing the means to assess competencies for osteopathic medicine and related health care professions. The NBOME's COMLEX-USA examination is recognized and accepted for licensure purposes by all U.S. medical and osteopathic medical licensing boards and in other countries around the world. We appreciate your recognition that COMLEX-USA evaluates the competencies required for delivering safe and high quality osteopathic medical care to patients. We stand along with the American Osteopathic Association (AOA), the AOA-Commission on Osteopathic College Accreditation (AOA-COCA), the American Society of Osteopathic Medical Regulators (ASOMR), and now the Accreditation Council for Graduate Medical Education (ACGME) in working with the nation's state licensing boards in stewarding professional self-regulation for the osteopathic medical profession and continuing to earn the trust of the patients we serve. We stand alongside the stellar University of New England College of Osteopathic Medicine (UNECOM) in Maine (where I served as Dean and Vice President for Health Services 2007-2009), the only osteopathic medical school in New England and the only DO or MD-granting school in Maine, in credentialing DOs who serve throughout the state since 1978. The osteopathic model continues to expand in the United States in part due to this trust and the current system that generates compassionate, committed and competent physicians who disproportionately care for patients in many of our nation's rural and underserved communities and specialties of need, including in Maine. With now about 200,000 total practicing DOs, residents and students, of the top six states in number of practicing DOs, four of these are states that entrust separate and distinct osteopathic medical licensing boards with the important responsibility in professional self-regulation, licensure and discipline in these states. Now over 25% of all medical students in the United States are choosing to attend a DO-granting school.

Thank you again for allowing us to listen in to deliberation of the "Board of Licensure in Medicine/Board of Osteopathic Licensure Workgroup" virtual meeting on August 27, 2025, led by



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BOLIM Executive Director, Timothy Terranova. In listening to the deliberations of the workgroup and reviewing the meeting materials provided, it became even more clear that having a separate and distinct BOLIM and BOL remains critical in protecting the public and positioning the state for responsiveness to projections for further physician shortages particularly in rural and other underserved areas in Maine. Maintaining two distinct boards would further protect the public by allowing the BOLIM to focus on likely challenges that may emerge in the near future, including the extensive work cited by Mr. Terranova that is required each year by BOLIM staff related to the licensure of international medical graduates (i.e., for IMGs-MDs) who complete postgraduate training accredited by “the Canadian Medical Association, the Royal College of Physicians of Canada or the Royal Colleges of England, Ireland or Scotland”. This was described by Mr. Terranova as “time-intensive work we have done for decades.” Now with the 2025 change of the Liaison Committee on Medical Education (LCME) no longer accrediting Canadian MD-granting schools and should the Maine legislature approve pending Maine House Bill 105 which would create a temporary license for IMGs, it is likely that the work of the Maine BOLIM will escalate significantly due to these changes in the upcoming years. As outlined by the authoritative “Advisory Commission on Additional Licensing Models (August 2025)” (see link below), recommended requirements and responsibilities of state medical boards for internationally trained physicians (ITPs) include extensive needs for assessment, supervision, communication, reporting, and verification to help the board in protecting the public. For osteopathic medicine and DOs and the BOL, there is only one osteopathic medical school accreditation authority (AOA-COCA), and one licensing examination (COMLEX-USA) and one GME accreditor (ACGME). It would make sense to an observer that it is unwise to encumber the BOL and osteopathic physicians with the escalating challenges faced by the BOLIM, including those that are unique to the BOLIM and not relevant to the BOL. This would seem to be another very good reason to support two separate and distinct boards at this time, and why the public of Maine and the legislature should support a solution that ensures that both boards are well resourced to fulfill their respective professional self-regulation responsibilities.

Finally, as the BOL appears to be financially self-sustaining from physician licensure fees and also appears to have funding for additional staff that has not yet been resourced for that purpose, there would be no benefit to the state or taxpayers from merging the two separate and distinct boards into a single board with divergent responsibilities. On the contrary, eliminating the BOL and the BOLIM and creating a new board would necessarily involve new administrative and training costs, as already discussed in the proposals, and will likely disrupt the efficient service that the BOL currently provides to Maine DOs, for the benefit of patients. Additional costs incurred due to the complexities of monitoring of IMGs and ITPs in the future will be more efficiently managed by a separate BOLIM, not complicating professional self-regulation or DOs. While the BOL may be currently understaffed, adding some additional staff to the BOL and contracting between boards for select services (as done in numerous states) appears to be a more economically efficient approach rather than consolidating the boards. From the financial models presented during the meeting, it was not clear that there would be any cost efficiencies to creating a single board, and that is what numerous other states who have evaluated such mergers have determined in their deliberations, determining that the best



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course of action for the patients in their states was two strong, separate and distinct boards focused on what they each need to do for patients in their states.

For these reasons, the NBOME supports your collective and sincere efforts focused on protecting the public and considering what is best for them and for access to care throughout your great state. We believe that a strong, separate and distinct board for DOs, working collaboratively with a strong, separate, distinct board for MDs (MBBS, MCh and other international designations for MDs) is the solution that is in the best interests of the patients in Maine. We hope that the workgroup comes to this conclusion as does the BOLIM and the BOL and that the two boards and the workgroup provide the Maine legislature with a unified vision and recommendation for two strong boards, the BOM and the BOLIM. This, in our view, would be a victory for defensible and just professional self-regulation for both professions and related health care professions and the patients we have the privilege to serve.

Sincerely,

John R. Gimpel, DO, MEd
President & CEO

References:

[Advisory Commission on Additional Licensing Models](#) (August 2025)

Cc: Kathryn Brandt, DO, MS, MEdL, MOA, President
Jane E. Carreiro, DO, UNECOM, Dean & VP, Health Affairs
Kathleen S. Creason, MBA, AOA, Chief Executive Officer
Amanda Mahan, MOA, Executive Director
Raine Richards, JD, ASOMR VP, State & International Affairs

Terranova, Tim E

From: Terranova, Tim E
Sent: Friday, September 26, 2025 7:15 AM
To: 'Murray, Douglas'; MacArthur, Rachel
Cc: Gimpel, John; Kathleen Creason
Subject: RE: Follow-Up to Maine Workgroup
Attachments: NBOME for Dennis.pdf

Good Morning,

Thank you for your email.

I would like to take a moment to clarify my comments. I was not referring to the letter addressed to the workgroup, which was submitted appropriately. I was referring to the attached letter dated August 19th, 2025, (received 9/9/25) and signed by you.

As you can see, the address on the letter is :

Dennis E. Smith, Esq

Maine Board of Licensure in Medicine

137 State House Station

Augusta Maine, 04333

The first sentence reads, "On behalf of the National Board of Osteopathic Examiner's (NBOME), we want to congratulate you on your appointment to the Maine Board of Osteopathic Licensure."

I hope this information is helpful.

Tim

Timothy Terranova
Executive Director
Maine Board of Licensure In Medicine
(207) 287-6930

From: Murray, Douglas <DMurray@nbome.org>
Sent: Thursday, September 25, 2025 8:26 PM
To: Terranova, Tim E <Tim.E.Terranova@maine.gov>; MacArthur, Rachel <Rachel.MacArthur@maine.gov>
Cc: Gimpel, John <JGimpel@nbome.org>; Kathleen Creason <kcreason@osteopathic.org>
Subject: Follow-Up to Maine Workgroup

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Mr. Terranova and Ms. MacArthur,

Enclosed please find a letter addressing an issue raised during last night's Workgroup meeting. We are hopeful that the Workgroup will continue to have an open dialogue about the issues raised in both our September 9 letter and the recent letter from the AOA and we look forward to being a part of that discussion. If you have any questions, please let me know.

Best Regards,

Douglas Murray, Esq.

General Counsel
(610) 825-1712





THE NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS

101 West Elm Street, Suite 230
Conshohocken, PA 19428

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8765 West Higgins Road,
Suite 200, Chicago, IL 60631

August 19, 2025

Dennis E. Smith, Esq
Maine Board of Licensure in Medicine
137 State House Station
Augusta, ME 04333

Dear Mr. Smith,

On behalf of the National Board of Osteopathic Medical Examiners (NBOME), we want to congratulate you on your appointment to the Maine Board of Osteopathic Licensure. NBOME engages with the Federation of State Medical Boards along with the state licensing boards directly. We regularly provide updates about the COMLEX-USA program and our other assessment products, and we report news about our services in support of the vitally important work of the licensing community.

Founded in 1934, the NBOME is the leading assessment organization for the osteopathic medical profession. Our mission is to protect the public by providing the means to assess competencies for osteopathic medicine and related health care professions. The NBOME has developed and administers the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) series (Level 1, 2-CE, and 3) for osteopathic physicians, which is universally accepted and recognized for physician licensure in all 50 states. Passing scores on COMLEX- USA examinations indicate that the candidate's osteopathic medical knowledge and clinical skills have met an acceptable national standard for entry into osteopathic medical practice. Osteopathic medical students are also required to pass Levels 1 and 2-CE of the COMLEX-USA in order to graduate from an osteopathic medical school, in accordance with the Commission on Osteopathic College Accreditation (COCA) requirements.

For osteopathic physicians who may have been out of active practice or who otherwise require an assessment of their current knowledge and skills, the NBOME offers the Comprehensive Osteopathic Medical Variable-Purpose Examination (COMVEX), which provides licensing boards with an evaluation of a physician's knowledge of current osteopathic medical practice.

The NBOME also for the last several years has been exploring and piloting the development of an osteopathic clinical skills assessment program, the Core Competency Capstone (C3DO) in conjunction with various colleges of osteopathic medicine. The NBOME recently announced its intention to launch the C3DO program and incorporate this assessment into its COMLEX-USA program as an option for the verification of osteopathic clinical skills competencies as part of the eligibility requirements for COMLEX-USA Level 3 starting in 2028. More information on the C3DO program can be found on NBOME's website at: <https://www.nbome.org/assessments/clinical-skills/c3do/>



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The NBOME also welcomes any state board members who are interested in participating in NBOME activities; currently we have state board members serving on the NBOME Board of Directors as well as participating in NBOME test development, standard-setting, or other committee work as part of NBOME's 900+ member National Faculty. More information on the NBOME National Faculty can be found at:

- NBOME National Faculty - <https://www.nbome.org/who-we-are/national-faculty/>

Additionally, below are links to several of other of our resources that may be of interest to you:

- Licensure Board Information on NBOME's website - <https://www.nbome.org/resources-for/state-licensing-boards/>
- [The Osteopathic Examiner](#), a quarterly newsletter for licensure boards and other stakeholder groups. - <https://www.nbome.org/publications-reports/#osteopathic-examiner>
- NBOME Annual Report - <https://www.nbome.org/app/uploads/2025/03/NBOME-2024-Annual-Report.pdf>

We hope you find this information helpful. Please feel free to reach out to us whenever you have questions or if we can be of assistance to you.

Best regards,

Douglas Murray

Douglas Murray, Esq.

General Counsel

National Board of Osteopathic Medical Examiners

dmurray@nbome.org

cc: John R. Gimpel, DO, MEd, President and CEO, NBOME
Raine Richards, VP State and International Affairs, AOA

Terranova, Tim E

From: Murray, Douglas <DMurray@nbome.org>
Sent: Friday, September 26, 2025 10:56 AM
To: Terranova, Tim E; MacArthur, Rachel
Cc: Gimpel, John; Kathleen Creason
Subject: RE: Follow-Up to Maine Workgroup

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Tim,

Thanks for clarifying as it wasn't clear from your comment what you were referring to. This is a welcome letter we send out to all new members of medical boards in the US, and our administrative assistant must have used the wrong address for this particular letter we apologize. You can be assured there is no confusion at NBOME regarding the roles and responsibilities of each Board in Maine and as noted in our Sept. 9 letter, we feel both Boards are servicing their respective communities well under the existing structure.

Thanks,
Doug

From: Terranova, Tim E <Tim.E.Terranova@maine.gov>
Sent: Friday, September 26, 2025 7:15 AM
To: Murray, Douglas <DMurray@nbome.org>; MacArthur, Rachel <Rachel.MacArthur@maine.gov>
Cc: Gimpel, John <JGimpel@nbome.org>; Kathleen Creason <kcreason@osteopathic.org>
Subject: RE: Follow-Up to Maine Workgroup

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Good Morning,
Thank you for your email.
I would like to take a moment to clarify my comments. I was not referring to the letter addressed to the workgroup, which was submitted appropriately. I was referring to the attached letter dated August 19th, 2025, (received 9/9/25) and signed by you.
As you can see, the address on the letter is :
Dennis E. Smith, Esq
Maine Board of Licensure in Medicine
137 State House Station
Augusta Maine, 04333
The first sentence reads, "On behalf of the National Board of Osteopathic Examiner's (NBOME), we want to congratulate you on your appointment to the Maine Board of Osteopathic Licensure."
I hope this information is helpful.
Tim

Timothy Terranova
Executive Director
Maine Board of Licensure In Medicine

(207) 287-6930

From: Murray, Douglas <DMurray@nbome.org>

Sent: Thursday, September 25, 2025 8:26 PM

To: Terranova, Tim E <Tim.E.Terranova@maine.gov>; MacArthur, Rachel <Rachel.MacArthur@maine.gov>

Cc: Gimpel, John <JGimpel@nbome.org>; Kathleen Creason <kcreason@osteopathic.org>

Subject: Follow-Up to Maine Workgroup

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Mr. Terranova and Ms. MacArthur,

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Best Regards,

Douglas Murray, Esq.

General Counsel

(610) 825-1712



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. Purpose~~

~~The Maine Board of Medicine is the state regulatory agency charged with protecting the public through the licensing and regulation of physicians and physician assistants in Maine.~~

§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.

1. **Board.** "Board" means the Maine Board of Medicine established in Title 5, section 12004-A, subsection X.

~~2. **Commissioner.** "Commissioner" means the Commissioner of Professional and Financial Regulation.~~

3. **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.

4. **Osteopathic Physician.** "Osteopathic Physician" means a physician who graduated from medical school with a DO degree.

4. **Physician.** "Physician" means an allopathic or osteopathic physician or surgeon licensed by the Board.

5. **Physician ~~Assistant~~Associate.** "Physician ~~Assistant~~Associate" means a physician ~~assistant~~associate licensed by the Board.

6. **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, 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;

Commented [TT1]: At least three different Commissioners are mentioned throughout the statute

Commented [TT2]: Is this an appropriate definition

Commented [TT3]: 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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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.

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H. Maintaining adequate medical records pursuant to the standard of care.

I. The rendering of medical services by physician associates

J. "Collaborative agreement" means a document agreed to by a physician assistant 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.

K. "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.

L. "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.

M. "Physician" means a person licensed as a physician under this chapter or chapter 36. [PL 2019, c. 627, Pt. B, §17 (NEW).]

N. "Physician assistant" means a person licensed under section 2594-E or 3270-E.

O. "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.

P. "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 under the federal Controlled Substances Act, 21 United States Code, Section 812.

§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. License required

1. Unlicensed practice. 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.

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 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, ~~its sole purpose being to protect the public health and welfare. The board carries out this purpose by ensuring that the public is served by competent and honest practitioners and by establishing minimum standards of proficiency in the professions regulated by the board by testing, licensing, regulating and disciplining practitioners of those regulated professions.~~

§XXXX. Board membership

1. Membership; terms; removal. The board consists of 17 members appointed by the Governor as follows:

- A. Five allopathic physicians. Each physician member must hold a valid license under this chapter and must have been in the ~~actual clinical~~ practice of medicine in this State for a continuous period of five (5) years immediately preceding appointment.
- B. Five osteopathic physicians. Each physician member must hold a valid license under this chapter and must have been in the ~~actual clinical~~ practice of medicine in this State for a continuous period of five (5) years immediately preceding appointment.
- C. Four physician ~~assistant associates~~. Each physician ~~assistant associate~~ must hold a valid license under this chapter and must have been in the ~~actual practice of medicine~~ ~~clinical rendering of medical services~~ in this State for a continuous period of five (5) years immediately preceding appointment.

Commented [TT4]: This appears to be inconsistent with Title 10 8003-C. There is no reference to Title 17-A in existing law and it is inadvisable to do so here.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

D. Three 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 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, rule making, 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. Adjudicatory hearing panels shall to the extent possible be composed of three members of the same license type as the respondent licensee and at least one public member.~~

4. Meetings. The board shall hold ~~regular monthly meetings~~ a minimum of three regular meetings a year and any additional special meetings at a time and place the chair may designate.

5. Board Officers. The board shall elect the following officers, whose duties shall be enumerated by rule, to serve two-year terms: chair; vice-Chair, secretary. The secretary of the board shall perform such duties as delegated by the board ~~through rule, including but not limited to license application review functions.~~

[3266] 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, including license application review functions. 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:

Commented [TT5]: Discussion for boards - Do you want term limits?

Commented [TT6]: There was discussion about the size and composition panel but nothing definitive was determined.

Commented [TT7]: That section will need to be updated

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

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;

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 ~~mandated~~ 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 as tabulated and categorized by the annual statistical summary of the Physician Data Base of the Federation of State Medical Boards of the United States, Inc.~~

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

Commented [TT8]: Will need to update

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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. ~~Financial-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 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.

Notwithstanding any other provision of this subsection, if the board contracts with the Commissioner of Education to provide funds for the costs of positions for which the State has contracted at the University of Vermont College of Medicine, or the Tufts University School of Medicine, the terms of the contract between the board and the commissioner must be in accordance with the requirements of Title 20-A, chapter 421;

14. ~~Conduct Examinations.~~ The power to conduct examinations relevant to licensure.

14. 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;

15. 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;

16. 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;

17. 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;

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18. 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;

19. 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;

20. 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. ~~Failure to comply with a direction of the committee to submit to a mental or physical examination results in the immediate suspension of the license of the individual until the individual submits to the examination.~~

21. 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.~~

~~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. —22. **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.~~

§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.~~

Commented [TT10]: 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.

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DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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 or disclosure of confidential information. 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).]

Commented [TT12]: This section is a discussion point

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.

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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, ~~with licensure or application~~

1. ~~the~~ 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.

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DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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.

Commented [TT13]: Should this apply to info provided in a complaint?

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 ~~assistant~~ ~~associate~~ licensed ~~or privileged~~ by the board who accepts the privilege of ~~providing 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.

Failure to comply with a direction of the board or committee to submit to a mental or physical examination results in the immediate suspension of the license of the individual until the individual submits to the examination or if the individual is an applicant for licensure the denial of licensure.

Commented [TT14]: This is different than 3286, which is recommended

Pursuant to Title 4, section 184, subsection 6, the District Court shall immediately suspend the license of a physician or physician ~~assistant~~ ~~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 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 ~~assistant~~ ~~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 ~~assistant~~ ~~associates~~

1. Qualification for licensure. The board may issue to an individual a license to practice as a physician ~~assistant~~ ~~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 or certificate of registration 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 \$300; 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 assistant/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 assistant/associate;
- C. Requirements for collaborative agreements and practice agreements, including uniform standards and forms;
- D. Requirements for a physician assistant/associate to notify the board regarding certain circumstances, including but not limited to any change in address, the permanent departure of the physician assistant/associate from the State, any criminal convictions of the physician assistant/associate and any discipline by other jurisdictions of the physician assistant/associate;
- E. Issuance of temporary physician assistant/associate licenses;
- F. ~~Appointment of an advisory committee for continuing review of the physician assistant rules. The physician assistant members of the board must be members of the advisory committee;~~
- G. Continuing education requirements as a precondition to continued licensure or licensure renewal;
- H. Fees for the application for an initial physician assistant/associate license, which may not exceed \$300; and
- I. Fees for the biennial renewal of a physician assistant/associate license in an amount not to exceed

\$250.

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.

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

§3270-H. Criminal history record information; fees

Commented [TT15]: Need a discussion on raising the cap on all fees. They don't need to be raised now, but to plan for the future.

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DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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 assistant 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
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 assistant 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 from which the licensee is applying. 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.

~~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.~~

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

~~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.~~

~~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.~~

~~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.~~

~~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 2A.~~

~~**§XXXX. Full Qualification for licensure of as allopathic physicians**~~

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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;

B. Graduate from an unaccredited medical school, be evaluated by the Educational Commission for Foreign Medical Graduates and ~~receive~~ hold a ~~permanent~~ current certificate from the Educational Commission for Foreign Graduates; or

C. Graduate from an unaccredited medical school and achieve a passing score on ~~the Visa Qualifying Examination or another~~ 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 ~~Visa Qualifying Examination~~.

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.

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.

Commented [TT16]: THE LCME stopped accrediting Canadian schools on 6/30/25. We need to discuss how to proceed with Canadian students.

Commented [TT17]: 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 met the Medical Education, Postgraduate training and Examination requirements.

3. 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.

4. 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.

5. Fees. Each applicant shall pay a fee up to \$600 plus the cost of the qualifying examination or examinations.

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6. 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.

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7. 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 ~~must~~ may be paid-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.

~~**8. 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.~~

§XXXX. Full Qualification for licensure of as an 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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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.

3. 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.

4. Fees. An applicant must pay a fee up to \$600 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.

5. 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.

~~**6. Special license categories.** The board may issue a license limited to the practice of administrative medicine, or any other special license, as set forth by routine technical rule of the board adopted pursuant to Title 5, chapter 375, subchapter 2-A.~~

§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

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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.

5. ~~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. ~~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.~~

5b. 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. ~~The fee for this license may be not more than \$300.~~

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.~~

6. 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.

7. Contract students. An applicant who is qualified under section XXXX who received a medical education as a contract student as provided in Title 20-A, chapter 421, and who agrees to practice in a primary care or other specialized area as defined in Title 20-A, section 11803, subsection 2, or an underserved area as defined in Title 20-A, section 11802, is considered to have completed the

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postgraduate training requirements of section XXXX, subsection XXXX, upon satisfactory completion of at least 12 months in a graduate educational program approved as specified in section XXXX. The board may make the relicensure of an individual for 4 years after the individual's licensure under this subsection contingent on the individual's continuing to practice in an underserved area. This subsection applies only to individuals entering into a contract under Title 20-A, chapter 421, on or before December 31, 1984. The fee for this license may be not more than \$300.

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

1. Renewal of ~~full~~ licenses. ~~Except as otherwise provided in this chapter, a~~ physician of physician ~~assistant~~associate with a ~~full~~ 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 full license~~ renewal that is valid for no longer than 2 years.

A. ~~Beginning with licenses expiring after July 1, 1994, r~~Regardless of the date of initial licensure or last license renewal, the license of every physician and physician ~~assistant~~associate born in an odd-numbered year expires at midnight ~~in 1995~~ on the last day of the month of the individual's birth ~~in every odd-numbered year~~. The license of every physician and physician ~~assistant~~associate born in an even-numbered year expires at midnight ~~in 1996~~ on the last day of the month of the individual's birth ~~in every even numbered year~~. ~~Upon Prior to~~ expiration, a physician or physician ~~assistant~~associate must renew the license issued pursuant to this section ~~and this license must be renewed every 2 years by the last day of the month of birth of the individual seeking license renewal~~ 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 ~~full~~ 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 ~~full~~ 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 ~~full~~ license, the license immediately and automatically lapses. The board may reinstate a ~~full~~ license that has lapsed pursuant to subsection 4.

2. Criteria for full 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 ~~full~~ 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, ~~including advising or prescribing medication for self, friends or family with or without charge~~, unless the board has found the licensee

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DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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 \$500 to all applicants for full license renewal.

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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.

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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 ~~full~~ 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 ~~full~~ 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 ~~full~~ 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.

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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 continuously for at least during the past 12-24 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 by passage of written examinations or practical demonstrations as the board may from time to time prescribe for this purpose 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.

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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 composition of investigative committees are subject to the following. An investigation committee must contain, if possible:

- A. If the investigation involves allegations against an allopathic physician: Two allopathic physicians, one osteopathic physician, one physician ~~assistant~~associate, and one public member.
- B. If the investigation involves allegations against an osteopathic physician: Two osteopathic physicians, one allopathic physician, one physician ~~assistant~~associate, and one public member.
- C. If the investigation involves allegations against a physician ~~assistant~~associate: Three physician ~~assistant~~associates, one physician, and one public member.

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. ~~Failure to comply with a direction of the committee to submit to a mental or physical examination results in the immediate suspension of the license of the individual until the individual submits to the examination.~~
- 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

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DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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. Consent agreements may be entered into only with the consent of the applicant or licensee, the 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 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.

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

1. **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 4, 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:

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

- 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:
- (1) 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
 - (2) 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.~~Unprofessional conduct. A licensee is considered to have engaged in unprofessional conduct if the licensee violates a standard of professional behavior that has been established in the practice for which the licensee is licensed or authorized by the board;~~
- 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 ~~narcotic or hypnotic or other~~ 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, for addiction to alcohol or drugs or for mental illness in accordance with Title 24, section 2505, ~~except when the impaired physician is or has been a patient of the licensee or the physician has been referred to the Medical Professionals Health Program;~~
- 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 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

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N. 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;

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

P. 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;

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

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

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

2. Judicial review. Notwithstanding any provision of Title 10, section 8003, subsection 5-A to the contrary, any nonconsensual revocation pursuant to Title 10, section 8003, subsection 5-A 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-A, 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 ~~assistant~~associates

A physician or physician ~~assistant~~associate may delegate to the physician's or physician ~~assistant~~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 ~~assistant~~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 ~~assistant~~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 ~~assistant~~associate ensures that the employees or support staff perform these delegated activities competently and safely. The physician or physician ~~assistant~~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 ~~assistant~~associate's agent. This section may not be construed to apply to

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

registered nurses acting pursuant to Chapter 31 or physician ~~assistant~~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 ~~assistant~~associates; scope of practice and agreement requirements

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings:

A. "Collaborative agreement" means a document agreed to by a physician assistant 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.

B. "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.

C. "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.

D. "Physician" means a person licensed by the board.

E. "Physician assistant" means a person licensed by the board.

F. "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.

G. "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 under the federal Controlled Substances Act, 21 United States Code, Section 812.

2. Scope of practice. A physician ~~assistant~~associate may ~~provide-render~~ any medical service for which the physician ~~assistant~~associate has been prepared by education, training and experience and is competent to perform. The scope of practice of a physician ~~assistant~~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.

3. Dispensing drugs. Except for distributing a professional sample of a prescription or legend drug, a physician ~~assistant~~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.

4. Consultation. A physician ~~assistant~~associate shall, as indicated by a patient's condition, the education, competencies and experience of the physician ~~assistant~~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 ~~assistant~~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.

5. Collaborative agreement requirements. A physician ~~assistant~~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 ~~assistant~~associate's scope of practice, except that a physician ~~assistant~~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 ~~assistant~~associate is legally responsible and assumes legal liability for any medical service provided by the physician ~~assistant~~associate in accordance with the physician ~~assistant~~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 ~~assistant~~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 ~~assistant~~associate is no longer subject to the requirements of this subsection.

6. Practice agreement requirements. A physician ~~assistant~~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 ~~assistant~~associate has a practice agreement with an active physician, and other health care professionals as necessary, that describes the physician ~~assistant~~associate's scope of practice. A physician ~~assistant~~associate is legally responsible and assumes legal liability for any medical service provided by the physician ~~assistant~~associate in accordance with the physician ~~assistant~~associate's scope of practice under subsection 2 and a practice agreement under this subsection. A physician ~~assistant~~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 ~~assistant~~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 ~~assistant~~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.

7. 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 ~~assistant~~associates, this section must be liberally construed to authorize physician ~~assistant~~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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

A physician or physician ~~assistant~~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 ~~assistant~~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

~~person licensed to practice medicine or render medical services under this chapter, or privileged under the PA Compact. An allopathic physician licensed pursuant to chapter 48, an osteopathic physician licensed pursuant to chapter 36,~~ 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 ~~Commissioners of the Profession 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

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DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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. ~~On or after January 1, 2017, w~~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. ~~On or after January 1, 2017, w~~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 ~~as a condition of prescribing 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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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 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 assistant associates in Maine:

1. Timeline for implementation

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 assistant associates in Maine.

Commented [TT24]: §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.

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 it as set forth in this Act to develop the budget for the Maine Board of Medicine.

**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 public 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

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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

- 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;

Commented [TT2]: BOLIM suggested change:
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.

Commented [TT3]: Discussion for boards - Do you want term limits?

Commented [TT4]: That section will need to be updated

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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DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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.

§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

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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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.

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

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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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 6/30/25. 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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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.

§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.

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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.

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 relicensure. 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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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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DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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

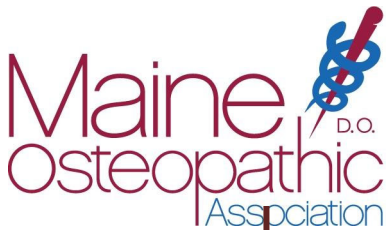
§XXXX. Transition. Notwithstanding the Maine Revised Statutes, Title 32, Chapters 36 and 48, the following provisions apply to the reassignment of the duties and responsibilities related to the licensing and regulation of allopathic physicians, osteopathic physicians and physician associates in Maine:

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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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 _____



November 12, 2025

MOA Executive Committee

Kathryn Brandt, D.O.
President

Josephine Conte, D.O.
President-Elect

John Diefenderfer, D.O.
Treasurer

Jodie Hermann, D.O., MBA
Immediate Past President

MOA Board of Directors

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Karen Benezra, D.O.

Jennifer Eaton, D.O.

Breanna Glynn, D.O.

Thomas Pentzer, D.O.

K. Emily Redding, D.O.

Tristan S. Reynolds, D.O.

Mary Yee, D.O.

UNECOM Student Representative
Keely Thomas, OMS-I

Resident Representative
Jacqueline Camm, DO

MOA Staff

Amanda Mahan,
Executive Director

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



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

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 richards@osteopathic.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert Piccinini, DO, D.FACN". The signature is fluid and cursive, with the last name "Piccinini" being the most prominent part.

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

Board of Licensure in Medicine - Board of Osteopathic Licensure
Workgroup
ZOOM meeting
December 17, 2025
5:31 p.m. – 6:51 p.m.

Board Members Present

Public Member Peter Michaud, JD, RN (BOL)
Paul Vinsel, DO (BOL)
Gust Stringos, DO (BOL)
John Brewer, DO (BOL)
Lisa Ryan, DO (BOL)
Christine Munroe, DO (BOL)
Public Member Mary-Anne Ponti, RN, DBA (BOL)
Public Member Lynne Weinstein (BOLIM)
Renée Fay-LeBlanc, MD (BOLIM)

Board Staff Present

Rachel MacArthur, Executive Secretary (BOL)
Timothy Terranova, Executive Director (BOLIM)
Maureen Lathrop, Administrative Assistant (BOLIM)
Valerie Hunt, Assistant Executive Director (BOLIM)
Paul Smith, MD, Medical Director (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 stated that Osteopathic Board Representatives Dennis Smith, public member and John Brewer, DO attended the BOLIM meeting on December 9th and provided really helpful background regarding the reasons why equal number of MDs and DOs on the board is necessary to move forward. The majority of BOLIM members felt comfortable moving forward and voted to move forward with merger with an equal number of MDs and DOs as recommended by the workgroup.

Dr. Munroe reported that board members had a lengthy discussion at the BOL meeting on December 11th and that many members listened to the BOLIM meeting. They heard that things went well in terms of where DOs were coming from. They are all heartened by the idea of working together on a board, putting the past behind them and focusing on the future of their profession. BOL unanimously voted to move forward with merger with the specific language of equal number of MDs and DOs on the board.

Review of Draft Statute

Workgroup members discussed the “Individual license” section on page three of the draft statute. Mr. Terranova noted that the language is slightly different than the language in the current statute. Mr. Michaud asked if there is language somewhere in statute that says the services of an NP are not medical services, and if the language in the draft statute could somehow limit NP practice.

Workgroup members agreed that the preamble written by Dr. Vinsel should remain in the statute.

Workgroup members discussed Board membership. The members have been assuming that current members of both boards will serve on the merged board. AAG Willis indicated that specific language can be added to the draft statute to clarify that current members of both boards will serve on a merged board until the expiration of their current terms. The workgroup agreed that the number of public members should be increased to keep the proportions the same as they currently are, and that committee membership will need to be adjusted accordingly.

The workgroup discussed the FOAA section on pages seven and eight of the draft statute. Mr. Terranova briefly explained this section of the current statute, the number of FOAA requests received by BOLIM and the number of requests received to withhold certain information from the FOAA requestor. If a request is made to withhold information due to a personal safety risk, the board must review and make a determination. AAG Wilson commented that BOL has also gone through this process which is cumbersome. AAG Willis said a more nuanced recommendation may be to offer the opportunity to review the information and request that any personal information be withheld. The boards always want to respect confidentiality, and this process would allow licensees to potentially find personal information that was missed during staff review. Following discussion, the workgroup agreed that items 1-3 of this section should be kept and the rest removed.

Mr. Terranova stated that staff included raising the cap on every fee by \$100 to have room to grow in the future. Workgroup members were in agreement.

Mr. Terranova discussed qualifications for licensure on page twelve of the draft statute. Medical schools in Canada are no longer accredited by the LCME. BOLIM is generally in agreement to accept the new accreditation body so Canadian students continue to qualify for licensure.

Obtaining educational and postgraduate training for foreign medical graduates is often a difficult and labor-intensive process. Mr. Terranova proposed that applicants who have graduated, trained and are licensed and registered in either England, Scotland, Ireland or Canada are deemed to meet the Medical Education, Postgraduate training and Examination requirements.

Mr. Terranova stated that BOLIM currently has a consultative telehealth license and recommended discontinuing the license. The license allows physicians to consult with a physician, advanced practice registered nurse or physician associate licensed in Maine who retains ultimate authority over the diagnosis, care and treatment of the patient. There is often confusion regarding the license. Mr. Terranova suggested working with the 50 – 60 physicians who currently hold this license to transition to a clinical license if they want to keep a Maine

license.

Mr. Terranova stated that a section regarding complaints and investigations in progress at the time of merger was added. The language specifies that pending complaints and investigations will be assigned to a committee of the combined board for review. This section includes language stating that no licensee with a pending matter at the time of merger may challenge a member of the committee that heard the matter while sitting as a member of BOLIM or BOL.

The workgroup discussed an enactment date for the statute and whether this should be at the beginning of a calendar or fiscal year. Following discussion, the workgroup agreed that January 1, 2027 is likely the soonest date that made sense based on logistics.

Review of Proposed Budget

Mr. Terranova presented a more detailed budget for a combined board. This was reviewed along with current revenue amounts and scenarios for establishing identical fees for MDs and DOs. The budget was broken into one time costs for a merger and ongoing costs of administering the program.

Mr. Terranova noted that for the time period of 2021-2025 revenues for both boards were higher than projected. A combined board would have sufficient budget to cover expenses.

The discussion included agreement that licensing fees need to be the same for MDs and DOs on a merged board. Four scenarios were provided for review. Both Dr. Fay-LeBlanc and Dr. Vinsel expressed that their preference would be scenario four, which sets initial application fees at \$700 (\$600 plus a \$100 jurisprudence fee) and renewals at \$500.

Mr. Terranova said that he discussed legal representation with the AG's Office and the recommendation is for a merged board to have two full-time AAG's for adequate representation, especially with a two-committee structure.

Review of Draft Report to the Legislature

Workgroup members were pleased with the draft report to the legislature. Mr. Michaud commented that the report was beautifully done. Dr. Munroe requested that language be added that BOL voted in favor of merger based on the specific language regarding equal representation on the board.

Outstanding issues

- Term limits – The workgroup did not make a recommendation on term limits.
- Inspection or copying of record – The workgroup recommends keeping items 1-3 and removing the remaining items.
- Raise statutory cap – The workgroup recommends raising the statutory cap on fees.
- Modify requirements for international medical graduates – The workgroup recommends modifying this section.

- Consultative telehealth registration – The workgroup recommends removing this license type.
- Effective date – The workgroup recommends January 1, 2027 as the soonest effective date based on logistics.
- Any statute that references the two current statutes will need to be changed to reference the new statute.
- Budget – The workgroup recommends providing budget numbers as discussed.
- Physician Associates – Mr. Terranova explained that physician associates licensed by BOLIM and BOL can have the same license number; both boards use the prefix PA for physician associate licenses. This will have to be addressed when the boards merge so that each PA is assigned a unique license number and historical information is retained. The easiest fix for historical purposes is to add a letter to BOL license numbers – O could be used to indicate licensure by the osteopathic board. Active licensees of the BOL will need to be assigned a new license number. A similar issue occurred in 2016 when PAs were no longer licensed by both boards and chose a board. Board staff worked closely with affected licensees to transition. This will not be an issue for physician licensees whose license numbers have an MD or DO prefix.

Ms. Ponti suggested that we reach out to other states who have merged boards to see what kind of a plan they put together for the “nitty gritty” details. Mr. Terranova stated that he plans to share draft legislation with other board executives to obtain feedback on any issues we might be missing. The workgroup agreed a blueprint would be helpful. The FSMB may be a resource as well.

Next Steps

Mr. Terranova recommends that the workgroup continue to meet at least until the legislature acts. The workgroup should continue to move forward with the assumption that the legislation will pass. The workgroup should discuss topics such as how to approach the committee process, who might testify, and what kind of presentation should be made.

Public Comment

Kathryn Brandt, DO - Dr. Brandt thanked the workgroup for the care with which this process has been done and ensuring public comment and representation of constituents.

Laura Gurenlian, DO – Dr. Gurenlian stated that in earlier discussions she understood the intent was to have committees structured so that DOs would review complaints against DOs and MDs would review complaints against MDs, but she does not see that in the legislation.

Mr. Terranova responded that the workgroup does not respond to comments from the public but stated that the draft statute breaks the board into two committees with equal representation on each committee.

Jodi Hermann, DO - Dr. Hermann thanked the workgroup for allowing the public to listen to the meetings and for all the efforts and sincerity. Dr. Hermann stated that the two professions

walking hand in hand in an equitable format will be good for everyone in the state.

Adjourn 6:51

Board of Licensure in Medicine/Board of Osteopathic Licensure Workgroup
161 Capitol Street
Augusta, Maine 04333-0137
December 17, 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/81229039006>

Meeting ID: 812 2903 9006 **Passcode:** 89697714 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 Draft Statute
 - IV. Review of Proposed Budget
 - V. Review of Draft Report to the Legislature
 - VI. Next Steps
 - VII. Public Comment
 - VIII. Adjourn

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,

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

- 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;

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

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.

§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

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.

§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.

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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.

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.

§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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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.

§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.

§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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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

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

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

DRAFT STATUTE FOR COMBINED MEDICAL BOARD

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 _____

	BOLIM	BOL	One-time	On-going	Combined
Licensees	9,865	1,951			11,816
Board Members	11	11		-2	20
Reduction				-2	
Employees	12	2	-	-	14
Existing staff	12	2	-	-	14
<i>New staff, none</i>			-	-	-
Cash Balance	\$6,159	\$1,029	-	-	\$7,188
<i>*projected at end of FY26</i>					
Revenues	\$2,546	\$427	-	-	\$2,973
Transfers, financial	(\$191)	(\$29)	-	-	(\$220)
PERSONAL SERVICES	\$1,669	\$202	-	\$11	\$1,882
Existing staff	\$1,669	\$202	-	-	\$1,871
<i>Stipends increase for Osteo Board, 9</i>			-	\$11	\$11
ALL OTHER	\$1,121	\$260	\$195	\$242	\$1,818
Contracts	\$353	\$18			\$371
<i>Additional contracts for evaluators</i>				\$25	\$25
AAG & SESC	\$365	\$171			\$536
<i>Additional AAG services, need 2 full-time</i>				\$194	\$194
Travel	\$27	-			\$27
<i>Increase travel for Osteo Board members reimb</i>				\$5	\$5
Rents	\$94	\$16			\$110
<i>Office Space renovation/reconfig</i>			\$20		\$20
General Ops	\$88	\$21			\$109
<i>Renaming/rebranding</i>			\$25		\$25
<i>Reduction in association costs (redundant)</i>				(\$4)	(\$4)
Tech	\$131	\$17			\$148
<i>Additional laptops for 9 Board members</i>				\$22	\$22
<i>Merging of databases</i>			\$130		\$130
<i>New website</i>			\$20		\$20
Office & supplies	\$13	\$2			\$15
Other Expenses	\$19	\$4			\$23
STACAP	\$31	\$11			\$42
<i>*Expense amounts in \$K</i>					

Budgeted vs. Actual Revenue - *Revenue amounts in \$K				
	BOLIM			BOL
2021				
Budgeted	\$1,673			\$247
Actual	\$2,296			\$370
2022				
Budgeted	\$1,906			\$349
Actual	\$2,509			\$415
2023				
Budgeted	\$1,901			\$365
Actual	\$2,701			\$433
2024				
Budgeted	\$2,288			\$387
Actual	\$2,756			\$491
2025				
Budgeted	\$2,395			\$371
Actual	\$2,937			\$502

Possible Revenue Changes *Estimated Figures Only*				
	Fee	Issued	Amount	
Current				
BOLIM Initi	\$700	1000	\$700,000	
BOL Initial	\$350	150	\$52,500	
BOLIM Ren	\$500	4000	\$2,000,000	
BOL Renew	\$525	1000	\$525,000	
Total				\$3,277,500
Possibility 1				
BOLIM Initi	\$600	1000	\$600,000	
BOL Initial	\$600	150	\$90,000	
BOLIM Ren	\$500	4000	\$2,000,000	
BOL Renew	\$500	1000	\$500,000	
Total				\$3,190,000
Possibility 2				
BOLIM Initi	\$600	1000	\$600,000	
BOL Initial	\$600	150	\$90,000	
BOLIM Ren	\$525	4000	\$2,100,000	
BOL Renew	\$525	1000	\$525,000	
Total				\$3,315,000
Possibility 3				
BOLIM Initi	\$350	1000	\$350,000	
BOL Initial	\$350	150	\$52,500	
BOLIM Ren	\$525	4000	\$2,100,000	
BOL Renew	\$525	1000	\$525,000	
Total				\$3,027,500
Possibility 4				
BOLIM Initi	\$700	1000	\$700,000	
BOL Initial	\$700	150	\$105,000	
BOLIM Ren	\$500	4000	\$2,000,000	
BOL Renew	\$500	1000	\$500,000	
Total				\$3,305,000



Janet T. Mills
Governor

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION
BOARD OF LICENSURE IN MEDICINE

Renée M. Fay-LeBlanc, MD
Board Chair

Timothy Terranova
Executive Director



Joan F. Cohen
Commissioner

January ____ 2026

Senator Donna Bailey, Chair
Representative Kristi Mathieson, Chair
Committee on Health Coverage, Insurance and Financial Services
100 State House Station
Augusta, ME 04333

RE: LD805 Resolve, to Direct the Board of Licensure in Medicine and the Board of Osteopathic Licensure to Conduct a Study Regarding the Feasibility of Combining Those Boards

Dear Senator Bailey, Representative Mathieson and members of the committee,

Following discussion of LD805, the Committee on Health Coverage, Insurance and Financial Services sent a letter requesting that the Board of Licensure in Medicine (BOLIM) and the Board of Osteopathic Licensure (BOL) continue the work they had started to study the feasibility of merging the two boards and report back to the committee no later than January 15, 2026.

RECOMMENDATION

The BOLIM/BOL workgroup recommends merger of the two Boards. To assist the Committee and the Legislature, the workgroup provides the attached proposed legislation addressing how to feasibly merge the two boards at this time.

At their December 2025 regularly scheduled board meetings, BOLIM and BOL voted in support of this recommendation and the attached proposed legislation, which includes the same number of MD and DO board members.

Just prior to this unified recommendation, at their November 2025 board meeting, BOLIM initially voted in favor of the merger, but not in favor of the single aspect of the draft statute that specified the physician members must be comprised of six osteopathic and six allopathic physicians. Following additional discussion at the November 2025 workgroup meeting and the December 2025 BOLIM meeting, BOLIM voted in favor of both the merger and the proposed statutory language constituting the physician representation on the merged board of six osteopathic and six allopathic physicians.

MEETINGS

Office Location: 161 Capitol Street Augusta, ME 04330
Mailing Address: 137 State House Station, Augusta, Maine 04333
www.maine.gov/md

Phone: (207) 287-3601

TTY: Please Call Maine Relay 711

Consumer Assistance: (888) 365-9964

Fax: (207) 287-6590

The BOLIM/BOL Workgroup met twelve (12) times during 2025:

- January 28, 2025 7 BOLIM members and 5 BOL members in attendance.
- February 26, 2025 3 BOLIM members and 5 BOL members in attendance.
- March 26, 2025 4 BOLIM members and 8 BOL members in attendance.
- April 30, 2025 2 BOLIM members and 5 BOL members in attendance.
- May 28, 2025 2 BOLIM members and 4 BOL members in attendance.
- June 25, 2025 2 BOLIM members and 7 BOL members in attendance.
- July 23, 2025 2 BOLIM Members and 7 BOL members in attendance.
- August 27, 2025 2 BOLIM members and 7 BOL members in attendance.
- September 24, 2025 2 BOLIM members and 5 BOL members in attendance.
- October 22, 2025 3 BOLIM members and 7 BOL members in attendance.
- November 19, 2025 5 BOLIM Members and 7 BOL members in attendance.
- December 17, 2025

Meeting notes and information reviewed at the meetings can be found at <https://www.maine.gov/md/about/merger>.

PUBLIC NOTICE

The workgroup instructed that a webpage be created to list upcoming meetings and provide notes and materials from previous meetings. The webpage, <https://www.maine.gov/md/about/merger>, went live on April 11, 2025. Prior to that, notice of all workgroup meetings were posted on the BOLIM and BOL websites and notice was sent to the Maine Osteopathic Association (MOA), Maine Medical Association (MMA), Maine Hospital Association (MHA) and Maine Academy of Physician Associates (MEAPA). In addition, BOLIM issues a newsletter to its licensees and interested parties three times a year. All three newsletters in 2025 included information about the workgroup and how to participate. The newsletters can be found at <https://www.maine.gov/md/about/newsletter>.

SUMMARY OF WORKGROUP MEETINGS

January 28, 2025 meeting: The discussion involved 13 topics, including board membership and allocation of representation among license types and public members, board structure, and differences in current licensing processes. Workgroup members requested the following additional information: information about states that recently combined boards, if possible, a presentation by the Federation of State Medical Boards (FSMB) about how states handle separate or combined boards, and the experiences of merging boards, and for BOL members to gather feedback from the Maine Osteopathic Association Winter Symposium.

February 26, 2025 meeting: FSMB gave a presentation providing a historical context of medical and osteopathic boards, recent consolidations and key points to consider when contemplating merger of the Maine allopathic and osteopathic boards. Workgroup members asked if a comparison document could be created detailing the processes of both boards. In addition, to facilitate public input, the workgroup suggested that the MMA, the MOA, MEAPA, and the MHA be allocated time to make presentations at the next meeting. Finally, the workgroup opted to change the meeting time to evening hours to ensure board members who wanted to participate in the workgroup could attend future meetings.

March 26, 2025 meeting: The MOA indicated that its members were concerned that the study process be transparent and objective, preserve DO autonomy and representation, maintain profession specific licensing and disciplinary standards, protect osteopathic continuing education and standards, and that any merger result in

financial and operational efficiency. The MOA extended an invitation for BOL members to attend a membership meeting on June 14, 2025.

The MHA provided a slide presentation that listed potential benefits for its members, working with two Boards instead of three (BOLIM, BOL and the Board of Nursing, more standardization in terms of requirements for licensure, and alignment with other states. The MHA listed a potential barrier as all physicians needing 36 months of postgraduate training. Specifically in regard to training programs the MHA listed potential benefits as aligning licensing requirements for residents, saving time and money by working with only one Board, and having one set of rules for residents. The MHA listed a potential barrier as limiting the ability of residents to moonlight. Currently DOs can moonlight after 12 months and MDs can moonlight after 24 months.

The MMA indicated that it is neutral on the concept of merger, but that it may enhance human and financial resources leading to enhanced efficiency and responsiveness as well as more fairness in the complaint, investigation and adjudicatory processes. MMA also discussed that there is currently confusion for physicians who are involved in training programs who come from out of state and are only familiar with one Board. There was also a suggestion that a merger may be beneficial to the Medical Professionals Health Program.

MEAPA indicated it is supportive of a merger and that the current two Board system, where PAs are licensed by different boards, creates confusion for hospitals, health care facilities and the public.

A comparison document was provided and reviewed by the workgroup. The workgroup asked that a FAQ or fact sheet be created, a dedicated webpage be created, and that budgetary information for each Board be provided for the next meeting.

April 30, 2025 meeting: The dedicated webpage, <https://www.maine.gov/md/about/merger>, went live on April 11, 2025. Although hosted by BOLIM, a direct link to this website was posted simultaneously on BOL's homepage.

Current budgetary and financial information for each board as well as a draft conceptual budget were reviewed. A draft Q & A document was reviewed and workgroup members discussed the request of non-board members to be members of the workgroup. Legal counsel advised that this was in excess of the Boards' existing authority. Workgroup members discussed the process moving forward, as well as a meeting structure to ensure interested persons or entities could make verbal comments at workgroup meetings or submit written comments for review by workgroup members.

The MOA invited members of the workgroup to attend and participate in the MOA Annual Convention. The workgroup agreed that BOL members would attend. In addition, the workgroup determined that the entire May meeting would be dedicated to receiving public comment and directed that a court reporter be available.

Public Comment was received from MOA lobbyist Charlie Soltan and MOA president Jodie Hermann, DO.

May 28, 2025 meeting: The workgroup received written comments from Gretchen Preneta, PA; Donald Hankinson, DO; Jacey Goddard, DO; Judith Aldrich, DO; and the American Osteopathic Association (AOA). The MOA also submitted a summary of their member survey. Verbal Comments were received from MOA staff and MOA Board members, Amanda Mahan, Kathryn Brandt, DO, and Jodie Hermann, DO. In addition, Donald McFadden, DO, a retired physician living in Florida provided verbal comments.

Workgroup members discussed concerns that a merged Board would need sufficient representation of specialties to review cases fairly and Ms. McArthur (BOL staff) offered her comments that the BOL staff's workload is going to become unmanageable, and she needs additional resources to adequately support BOL.

June 25, 2025 meeting: The workgroup discussed a concern expressed during the May meeting that the Boards do not receive equal funding. It was explained that the Boards are funded by licensure fees and BOLIM, with approximately four times the number of licensees, has a correspondingly higher budget as a result. BOLIM and BOL staff indicated they had recently spoken with staff of merged boards in other states who indicated these mergers had been positive. A BOL Board member also indicated they had spoken with a board member of a recently merged board, who also provided positive feedback.

The workgroup discussed that there may be an ongoing and fundamental misunderstanding about the mission of the Boards and that there may be a general lack of knowledge of how the Boards operate. The workgroup members and staff reiterated that the Boards are state agencies tasked with protecting the public rather than with promoting the professions.

The workgroup reviewed information showing the increase in numbers of licensees for both Boards over the past ten years and discussed the increased workload that brings with it. BOL members asked for information regarding what it would cost to staff the BOL sufficiently to remain a separate Board and what the resulting increase in licensing fees would be required to generate a budget to support that staff.

There was brief discussion about the composition of a merged Board with an equal number of MDs and DOs and how the merged Board could divide into committees to review complaints and conduct hearings, while ensuring DOs were reviewed and adjudicated by other DOs. Workgroup members indicated they would bring the information about the workgroup discussions to date back to their respective Boards in July and vote on whether to continue moving forward and take the next step of creating draft legislation with specific details of the merged Board's structure, standards, and functions.

James Riley, DO submitted written comment. No verbal comments were submitted.

July 23, 2025 meeting: Workgroup members reported that both Boards voted to continue with the process, although BOL members indicated the BOL had a robust discussion regarding negative feedback from osteopathic physicians.

The workgroup reviewed and discussed draft legislation prepared by a BOL Board member for the workgroup's consideration. The workgroup reviewed and discussed the draft legislation.

In response to concerns, the workgroup discussed making materials available to the public prior to the workgroup's meetings. Following discussion, the workgroup asked that the information it would review at each meeting be posted to the website approximately one week before each meeting.

Public Comment was received from Jane Carreiro, DO, Dean of the College of Osteopathic Medicine at UNE; Kathryn Brandt, DO, President of the MOA; Robert Piccinini, DO, President of the American Osteopathic Association; Rich Thacker, DO, President Elect of the American Osteopathic Association; Amanda Mahan, Executive Director of the MOA; and Jodie Hermann, DO, Past President of the MOA.

August 27, 2025 meeting: The workgroup reviewed the Kentucky Board of Medical Licensure's committee structure for review of disciplinary matters, in which the Board members are divided into two separate committees to review and conduct hearings in disciplinary matters (with the Chair serving on both). Following discussion, the workgroup indicated support for the use of a similar process if BOL and BOLIM merge (without the Chair serving on both).

Workgroup members reviewed estimated mock-ups of budget numbers necessary for possibly increased BOL staffing to permit BOL to remain independent. The estimated budget mock-ups included three scenarios:

- Keeping BOL and BOLIM separate and adding four BOL staff positions to address specific BOL needs. This was estimated to result in renewal fees (paid every two years) increasing approximately \$438 for every DO licensee. The current DO renewal fee is \$525 and this scenario was estimated to require a biennial renewal fee to \$963.
- Keeping BOL and BOLIM separate and adding four staff to BOLIM (not necessary but for comparison only) would result in renewal fees (paid every two years) increasing for every MD license by approximately \$88. The current renewal fee is \$500 and this would bring the renewal fee to \$588.
- Merging the Boards and adding four staff (not necessary but for comparison only). This would result in renewal fees increasing for all MDs and DOs by approximately \$74.

The workgroup reviewed the draft statute and discussed several issues, changes, and concerns. Following discussion, the workgroup indicated it would continue its review at the next meeting.

Written comment was provided by Kerrigan Goudreau, DO a second-year medical student at UNE. Verbal comments were provided by Kathryn Brandt, DO; Rich Thacker, DO; John Gimpel, DO, from the National Board of Osteopathic Medical Examiners (NBOME); Teresa Hubka, DO, from the AOA; and John Diefenderfer, DO (Hallowell, ME)

September 24, 2025 meeting: The workgroup continued its review of the draft legislation and noted differences between the draft and BOLIM's current statute. The workgroup asked for licensing data from recently merged Boards and for information about whether such mergers influenced numbers of individuals seeking licensure as DOs. In addition, the workgroup asked for an in-depth, side-by-side comparison of existing Board statutes with the draft legislation for the merged board at the October meeting.

The work group reviewed letters from the National Board of Osteopathic Medical Examiners and a joint letter from the MOA and AOA. Public comment was received from Robert Piccinini, DO; Rich Thacker, DO; and John Diefenderfer, DO.

October 20, 2025 Meeting: The workgroup reviewed the previous Q&A document and had no comment. The workgroup reviewed a new Advantages/Disadvantages document and requested some additions. The workgroup also reviewed information that BOL is the only independent Osteopathic Board in the nation that does not have an executive director level administrator.

The workgroup reviewed licensing trends in states that recently merged and discussed that it appeared that no clear conclusions could be drawn from the information.

A side-by-side comparison of the current and proposed statutes was conducted and concerns were voiced regarding the structure and assigned membership of different committees proposed in the draft legislation.

The workgroup took a straw poll on the latest feeling among workgroup members about merger. Seven of the members present were in favor of recommending potential merger and one member abstained. The workgroup members were asked to bring the information back to the respective boards, along with the information reviewed over the past 10 months, for an official Board vote regarding support for the merger and the proposed legislation.

MOA and NBOME provided written comments. Public comment was received from Teresa Hubka, DO; Josie Conte, DO (MOA); and John Diefenderfer, DO.

November 19, 2025 meeting: The workgroup's discussion was devoted to the actions taken by the two Boards at their respective November regular board meetings. In particular, the discussion focused on BOLIM's vote, BOL member reactions to that vote, and BOL's decision to table its vote about whether or not to support merger.

At the November BOLIM meeting, BOLIM voted unanimously in favor of merging the boards; and also voted in opposition to the single issue in the draft legislation requiring six osteopathic and six allopathic physicians (2 members in favor and 6 opposed to the proposed composition of physician members). As an alternative to that language, and to keep moving the merger discussion forward, BOLIM also voted to propose two options for the composition of the physician members: (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."

At BOL's meeting immediately following BOLIM's, BOL tabled its vote until after the November 19th workgroup meeting.

At the workgroup meeting, BOL members expressed dismay and frustration over the apparent change in BOLIM's support for equal representation at what was felt to be the last minute of the process. BOL members indicated they did not believe the full BOL would support a merger if the proposed legislation did not include six osteopathic physicians and six allopathic physicians. Following discussion, the workgroup opted to have two members of BOL attend the December 9, 2025 BOLIM meeting to further explain the relevance and importance of this issue to the proposed merger.

The MOA and AOA provided written comments. Public comment was received from Robert Piccinini, DO; Kathryn Brandt, DO; and Jodie Hermann, DO

PROPOSED STATUTORY LANGUAGE

During the course of the workgroup's meetings, draft statutory language was provided by a BOL member and this document became the focus of much of the workgroup's efforts. As can be seen in the full meeting notes and materials, this draft legislation was updated several times. Although there is still some minor work that needs to be done, the workgroup concluded that the latest draft (attached) provides the best path forward in merging the boards while protecting the public and streamlining processes.

OUTSTANDING ISSUES IN THE PROPOSED DRAFT STATUTE

As indicated, the workgroup generally agreed on the draft language. However, there are several areas that require the attention of the Legislature, prior to enactment. These include:

- Term limits – there are currently no term limits for Board members, and while the workgroup discussed the benefits to both approaches, it did not reach a clear recommendation on this issue.
- Consider removal of 'Inspection or copying of record' – This provision (in current law 32 M.R.S. §§ 2600-E and 3300-H) was introduced in 2019 and requires that upon receipt of a FOAA request for an applicant's or licensee's files, the board shall compile those files and redact confidential information and then the boards must notify the applicant or licensee, who, upon timely request, may review the compiled redacted record, and may petition the Board and request that the Board not disclose otherwise non-confidential, public information on the basis that disclosure creates a potential risk to their personal safety or that of a third party. If the Board decides the applicant or licensee has not demonstrated such a potential risk to personal safety, the licensee may then initiate an action in Superior Court to obtain an injunction on the basis of the alleged potential risks to personal safety. The Right to Know Committee reviewed this issue in the summer of 2023 and, despite the Board's request, opted to keep the provision

on the basis that it was recently added. This section creates additional administrative time and cost burdens for every Board FOAA request, and invites multi-party and parallel litigation that further increases time and financial burdens on the Boards, diverting resources from their sole purpose to protect the public health and welfare by ensuring the public is served by honest and competent practitioners through licensing, regulation, and discipline. The Boards request the Committee and Legislature consider removal of this time and cost intensive provision that simply diverts valuable Board resources from its clear purpose and existing FOAA obligations.

- Request to raise the statutory cap on licensing fees - BOLIM initial application fees for physicians are higher than BOL initial application fees for physicians, while BOL renewal fees are higher than BOLIM renewal fees for physician licensees. The recommendation is that the fees should be consistent for all physicians licensed by the merged Board. Although there is no plan to raise licensing fees higher than the current highest amount charged (BOLIM initial fee and BOL renewal fee) a modest increase of \$100 of the statutory cap is recommended to provide room for future fee increases, if needed.
- BOLIM suggestion to modify current requirements regarding the recognition of international medical training – For decades BOLIM has recognized and accepted medical education and post graduate training received in Canada, the United Kingdom and Ireland for its allopathic physician licensees,. Obtaining the specific education and post graduate education training documentation can be difficult and time consuming. Is it reasonable to accept as fully trained and qualified anyone from these three areas that are fully licensed and/or registered?
- Interstate Consultative Telehealth Registration – In 2015 the legislature created a consultative telehealth registration (32 M.R.S. § 3300-D (BOLIM)). This registration is extremely limited and only allows a physician not licensed in this state to consult with a physician, or other appropriate health care practitioner (PA or APRN) licensed in Maine related to the care of patient over whom the Maine-licensed physician, PA, or APRN licensed in Maine retains ultimate authority to diagnose, treat and care for. Given the exponential increase in medical care provided through telehealth nationwide following the pandemic, this registration is confusing to applicants who believe they can see, speak with, and treat Maine patients with this registration, when none of those things is permitted. A significant amount of staff time is spent educating applicants who request this consultative telehealth registration at the application stage and BOLIM has disciplined physicians who have provided services directly to patients even after being educated and attesting they understand that the registration does not permit direct patient care or communication. There are approximately 52 individuals currently holding active registrations under this provision. BOLIM recommends the registration be discontinued and its staff will work with those current registrants to convert the registrations to full licenses or offer the registrants the chance to voluntarily withdraw the registrations.
- Effective Date - An effective date of the merger. If the legislature moves forward with a merger there are technical tasks that need to be completed, such as merging of databases, creation of a website, reconfiguration of office space, etc.
- There are also various other Chapters throughout Maine law that refer to the Boards' statutes, that will need to be updated, including Title 5 will need to be amended to establish the merged Board and provide for the Board member per diem rates. BOLIM staff will be happy to work with the Committee to provide a list of the known provisions that will also need to be updated at the time of enactment of a merged Board statute.

BUDGET

A draft budget has been prepared and is attached to this report. It contains a regular fiscal year budget, based on FY27 figures as well as a budget for one-time costs. It is expected that the one-time costs can come out of reserves with no additional costs to licensees.

PHYSICIAN ASSOCIATES

Physician Associates (PA) are currently licensed by both boards. Because the current licensing database works independently for both boards, a PA licensed with BOLIM may have the same license number as a PA licensed by BOL. We believe we can easily transfer expired and lapsed licenses. However, the approximately 60 PAs actively licensed by BOL will likely need to obtain new license numbers, which staff will work to assist them with in as seamless a manner as possible to ensure continuity of licensure and patient care. However, this may impact their credentialing, privileging at facilities and insurance enrollments.



TO: Members of the Maine Board of Osteopathic Licensure (BOL)

FROM: American Osteopathic Association

DATE: December 10, 2025

SUBJECT: Renewed Concerns Regarding BOL/BOLIM Merger Workgroup Proposal

Following the Maine Board of Licensure in Medicine (BOLIM) meeting on December 9th, the American Osteopathic Association (AOA) writes to share our renewed concerns with the proposal to merge the BOL and the BOLIM, which is scheduled for a vote during the BOL's December 11, 2025 meeting. Although the BOLIM ultimately voted – over dissent – to support the original proposal as drafted by the Board Merger Workgroup (Workgroup), which contains equal representation for osteopathic (DO) and allopathic (MD) physicians, it is clear that the BOLIM's preference would be enhanced specialty representation – not DO/MD parity. Although necessary to bring the Workgroup's product to its intended conclusion – a legislative proposal to merge the boards – we reiterate our concern that the final version of the bill is unlikely to contain equal representation, especially if the board with greater political power by “constituent” numbers is not privately supportive of parity. For these reasons, as well as those discussed in more detail below, we continue to strongly support maintaining a separate and distinct BOL.

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 Maine Osteopathic Association and the National Board of Osteopathic Medical Examiners, 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.

The BOL's thorough, DO-led approach to reviewing applications and complaints ensures the highest standards of professional conduct and patient safety. We 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 BOLIM 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 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*¹ 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

¹ Advisory Commission on Additional Licensing Models (August 2025). See <https://www.fsmb.org/siteassets/communications/acalm-guidance.pdf>.

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 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