Executive Committee Meeting

Virginia Board of Medicine
April 5, 2024
8:30 a.m.

PERIMETER CENTER CONFERENCE CENTER
EMERGENCY EVACUATION OF BOARD AND TRAINING ROOMS
(Script to be read at the beginning of each meeting.)

PLEASE LISTEN TO THE FOLLOWING INSTRUCTIONS ABOUT EXITING THESE PREMISES IN THE EVENT OF AN EMERGENCY.

In the event of a fire or other emergency requiring the evacuation of the building, alarms will sound.

When the alarms sound, leave the room immediately. Follow any instructions given by Security staff

Board Room 4

Exit the room using one of the doors at the back of the room. (**Point**) Upon exiting the room, turn **RIGHT.** Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

Executive Committee

Friday, April 5, 2024 @ 8:30 a.m.
Perimeter Center
9960 Mayland Drive, Suite 201, Board Room 4
Henrico, VA 23233

====No motion needed to adjourn if all business has been conducted====

Agenda Item: **Approval of Minutes of the August 4, 2023**

Staff Note: Draft minutes that have been posted on Regulatory Townhall and the Board's website are presented. Review and revise if necessary.

Action: Motion to approve minutes.

---DRAFT -UNAPPROVED---

VIRGINIA BOARD OF MEDICINE

EXECUTIVE COMMITTEE MINUTES

Friday, August 4, 2023 Department of Health Professions Henrico, VA

CALL TO ORDER: Dr. Clements called the meeting of the Executive Committee to order at 8:38 a.m.

ROLL CALL: Ms. Brown called the roll; a quorum was established.

MEMBERS PRESENT:
John R. Clements, DPM – President, Chair
Jane Hickey, JD
L. Blanton Marchese
Jacob Miller, DO
Joel Silverman, MD
Ryan P. Williams, MD

STAFF PRESENT:
Jennifer Deschenes, JD, MS – Deputy Exec. Director for Discipline
Colanthia Morton Opher - Deputy Exec. Director for Administration
Michael Sobowale, LLM - Deputy Exec. Director for Licensure
Arne Owens - DHP Director
Erin Barrett - DHP Director of Legislative and Regulatory Affairs
Matt Novak – DHP Policy Analyst
Barbara Matusiak, MD - Medical Review Coordinator
Deirdre Brown - Executive Assistant

OTHERS PRESENT:
James Rutkowski – Sr. Assist. Attorney General
Tamika Hines - Board Staff
Robert Glasgow – VAPA
Ashley Fine – HDJ
Michelle Satterlund - Macaulay Jamerson Satterlund & Sessa, P.C.
Clark Barrineau, MSV
Marinda Shindler – VMA
Kim Ketchersid – VAPA
Courtney Corboy – VAPA
Sarah Hamaker – VAPA
James Pickral - VRS

EMERGENCY EGRESS INSTRUCTIONS

Dr. Clements provided the emergency egress instructions for those in the building.

APPROVAL OF MINUTES FROM DECEMBER 2, 2022

Dr. Miller moved to approve the meeting minutes from December 2, 2022, as presented. The motion was seconded by Ms. Hickey and carried unanimously.

ADOPTION OF AGENDA

Dr. Miller moved to adopt the agenda as presented. The motion was seconded by Dr. Williams and carried unanimously.

PUBLIC COMMENT

Robert Glaskco, from the Virginia Academy of Physician Assistants, informed the Committee that he has been practicing as a physician assistant for over 30 years, and he appreciates being able to administer prescriptions and thanked the Committee for their support.

DHP DIRECTOR'S REPORT

Mr. Owens shared with the Committee that DHP is focused on the Virginia Healthcare workforce. He stated that DHP is in the middle of a Rand Corporation study which is expected to wrap-up by the end of September 2023. The purpose of the study is to gather information on concerns, problems and gaps in care, and to make recommendations to address such issues.

After providing an update on the Right Help, Right Now Initiative, Mr. Owens stated that due to a recent study, employees at DHP are being compensated at current market rates which will assist in staff retention. Next, Mr. Owens informed the members that DHP has submitted its 2024-2026 budget, which included an authorization request for additional full-time employees.

Additionally, Mr. Owens stated that DHP is preparing for the next General Assembly session. He gave an account that in the last General Assembly session 8 bills were moved forward in which 4 were DHP bills that were passed and signed by the Governor. Mr. Owens noted that on July 27, 2023, he gathered with other Government administration officials to discuss the key points that the Governor would like to deliver successfully by the end of his 4-year term, and the focus is on keeping the workforce healthy, safe and economical for families in Virginia.

PRESIDENT'S REPORT

No report.

ACTING EXECUTIVE DIRECTOR'S REPORT

No report.

NEW BUSINESS

1. Regulatory Actions as of July 10, 2023

Ms. Barrett presented the chart for review only.

2. Withdrawal of NOIRA regarding behavior analyst training

Ms. Barrett stated to the Committee that the existing regulations currently conform to the 2023 legislation. To be in compliance with the 2023 legislation, the Committee must take action to withdraw the regulatory action.

MOTION: Dr. Miller moved to withdraw the NOIRA regarding behavior analyst and behavior analyst assistant training filed in June 2022. The motion was seconded by Dr. Williams and carried unanimously.

3. Adoption of final regulations for the implementation of the Occupational Therapy Interjurisdictional Compact

Ms. Barrett reviewed with the Committee the proposed regulations for the OT Compact in Virginia and advised that no public comments were received.

MOTION: Dr. Williams moved to adopt final regulations implementing the OT Compact. The motion was seconded by Dr. Miller and carried unanimously.

4. Amendment of Guidance Document 85-10 regarding midwife disclosures

Ms. Barrett reviewed with the Committee the changes made to Guidance Document 85-10 by an ad hoc committee of the Board, which were also approved by Advisory Board on Midwifery.

MOTION: Dr. Miller moved to accept the amendments to Guidance Document 85-10 as recommended by the ad hoc committee and Advisory Board on Midwifery. The motion was seconded by Mr. Marchese and carried unanimously.

5. Adoption of the midwifery formulary and best practice/standards of care protocol

Ms. Barrett referred the Committee to the formulary and best practice/standards of care handout. Mr. Marchese shared with the Committee that the formulary and best practice standards were reviewed and recommended by the ad hoc committee.

MOTION: Mr. Marchese moved to adopt the formulary and best practice/standards of care protocol. The motion was seconded by Dr. Williams and carried unanimously.

6. Final Regulations for licensed certified midwives

Ms. Barrett referred the Committee to the handout of public comments received on Town Hall. She stated that 47 comments were received and all were in support with no changes to the new regulations for licensed certified midwives. Ms. Barrett informed the Committee that since this profession will be jointly regulated by the Board of Nursing, the Board of Nursing will vote on the

final regulations at their September 2023 meeting.

MOTION: Dr. Williams moved to adopt final regulations regarding licensure of licensed certified midwives. The motion was seconded by Dr. Miller and carried unanimously.

7. Petition for rulemaking regarding supervision of radiologist assistants

Ms. Barrett presented the options of actions to the Committee regarding supervision of radiologist assistants. She shared with the Committee that a total of 6 public comments were received, four were in support and 2 were in opposition.

MOTION: Ms. Hickey moved to take no action on the petition because the issue presented was not defined or developed enough for the Board to understand the scope of the changes requested. The motion was seconded by Dr. Silverman and carried unanimously.

8. Petition for rulemaking regarding use of physician name on prescriptions issued by physician assistants

Ms. Barrett shared with the members that 186 public comments were received on Town Hall and all were in support of the petition. Additionally, a letter of support from the Medical Society of Virginia (MSV) was distributed to the members for consideration. MSV stated that Virginia patients would, "see improved efficiency and healthcare delivery with these changes".

MOTION: Mr. Marchese moved to accept the petition and initiate rulemaking. The motion was seconded by Dr. Williams and carried unanimously.

9. Petition for rulemaking regarding consultation and collaboration requirements for patient care team physicians or podiatrists working with physician assistants

Ms. Barrett reviewed the Petition for Rulemaking that was filed by the Virginia Academy of Physician Assistants to amend 18VAC85-50-110(1). She stated that 29 public comments were received on Town Hall with none being in opposition.

MOTION: Ms. Hickey moved to accept the petition and initiate rulemaking. The motion was seconded by Mr. Blanton and carried unanimously.

10. Adoption of revised policy on meetings held with electronic participation pursuant to statutory changes

Ms. Barrett reviewed with the Committee the proposed revised electronic participation policy that is in accordance with Virginia Code § 2.2-3708.3.

MOTION: Mr. Marchese moved to adopt the revised policy on meetings held with electronic participation as presented. The motion was seconded by Ms. Hickey and carried unanimously.

ANNOUNCEMENTS

Ms. Deschenes informed the Committee of the updated guideline for travel reimbursement.

Effective immediately, board members must submit requests for reimbursement within 30 days of travel for reimbursement approval. No exceptions after the 30-day deadline will be accepted.

The next meeting of the Executive Committee will be December 1, 2023 @ 8:30 a.m.

ADJOURNMENT

With no additional business, the meeting adjourned at 9:43 a.m.

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Jennifer Deschenes, JD, MS
Acting Executive Director

Agenda Item: **DHP Agency Director's Report**

Staff Note: All items for information only

Action: None.

Agenda Item: **Board President's Report**

Staff Note: All items for information only.

Action: None.

Agenda Item: **Executive Director's Report**

Staff Note: All items for information only.

Action: None.

Agenda Item: **2024 General Assembly Report**

Staff Note: Ms. Barrett will speak to legislation of interest to the Board of Medicine.

Action: If any action is required, guidance will be provided.

Board of Medicine
Current Regulatory Actions
As of March 18, 2024

In the Governor's Office

VAC	Stage	Subject Matter	Submitted from agency	Time in current location	Notes
18VAC85-80	Final	Implementation of the OT Compact	8/23/2023	6 days	Replaces emergency regulations for participation in the OT Compact

In the Secretary's Office

VAC	Stage	Subject Matter	Submitted from agency	Time in current location	Notes
18VAC85-160	Final	Changes consistent with a licensed profession	6/17/2022	622 days	Proposed regulations consistent with surgical assistants changing from certification to licensure
18VAC85-160	Fast-track	Reinstatement as a surgical technologist	6/17/2022	566 days	Action to allow certified surgical technologists to voluntarily request inactive status, and for surgical technologists to reinstate certification from inactive status or from suspension or revocation following disciplinary action.
18VAC85-130	Fast-track	Implementation of changes following 2022 periodic review of Chapter	10/6/2022	293 days	Implements changes following 2022 periodic review

18VAC85-140	Fast-track	Implementation of changes following 2022 periodic review of Chapter	10/6/2022	290 days	Implements changes following 2022 periodic review
18VAC85-150	Fast-track	Implementation of changes following 2022 periodic review of Chapter	10/6/2022	287 days	Implements changes following 2022 periodic review
18VAC85-170	Fast-track	Implementation of changes following 2022 periodic review of Chapter	10/6/2022	287 days	Implements changes following 2022 periodic review
18VAC85-15	Fast-Track	Implementation of Periodic Review	10/6/2022	252 days	Implements changes following 2022 periodic review
18VAC85-40	Fast-track	Implementation of changes following 2022 periodic review of Chapter	10/6/2022	231 days	Implements changes following 2022 periodic review
18VAC85-80	Fast-track	Implementation of changes following 2022 periodic review of Chapter	10/6/2022	222 days	Implements changes following 2022 periodic review
18VAC85-50	NOIRA	Removal of patient care team physician or podiatrist name from prescriptions issued by physician assistants	8/8/2023	220 days	Regulatory action begun in response to a petition for rulemaking
18VAC85-50	Fast-track	Implementation of changes following 2022 periodic review of Chapter	8/15/2023	216 days	Implements changes following 2022 periodic review
18VAC85-110	Fast-track	Implementation of changes following 2022	10/6/2022	213 days	Implements changes following 2022 periodic review

		periodic review of Chapter			
18VAC85-50	NOIRA	Amendment to requirements for patient care team physician or podiatrist consultation and collaboration	8/8/2023	210 days	Regulatory action begun in response to a petition for rulemaking
18VAC85-20	Fast-track	Implementation of changes following 2022 periodic review of Chapter	10/6/2022	201 days	Implements changes following 2022 periodic review
18VAC85-21	Fast-track	Amendment of opioid and buprenorphine prescribing regulations	7/14/2023	45 days	Updates opioid and buprenorphine regulations based on updated CDC guidelines

At the Department of Planning and Budget

None.

At the Office of the Attorney General

VAC	Stage	Subject Matter	Submitted from agency	Time in current location	Notes
18VAC85-130	Fast-track	General disclosure requirement consistent with statutory changes	10/23/2023	147 days	Updates requirements for midwife disclosures consistent with 2023 legislative changes

Recently effective/awaiting publication

VAC	Stage	Subject Matter	Publication date	Effective date
18VAC85-101	Fast-Track	Implementation of changes following 2022 periodic review of Chapter	2/12/2024	3/28/2024
18VAC85-120	Fast-Track	Implementation of changes following 2022 periodic review of Chapter	2/12/2024	3/28/2024

Agenda Item: **Current Regulatory Actions**

Staff Note: Ms. Barrett will speak to the Board of Medicine actions underway.

Action: If any action is required, guidance will be provided.

Legislative Report
Board of Medicine
April 5, 2024

Duplicative bills have been removed from list.

HB 217 Hysterectomies and oophorectomies; DHP shall review informed consent requirements.

Chief patron: Orrock

DEAD BILL

Physicians; informed consent; disclosure of certain information prior to hysterectomy or oophorectomy. Requires physicians to obtain informed consent from a patient prior to performing a hysterectomy or oophorectomy. Prior to obtaining informed consent, physicians must inform the patient of the patient's freedom to withhold or withdraw consent, refer the patient to the Hysterectomy Educational Resources and Services (HERS) Foundation, and provide the patient with anatomical diagrams relevant to the procedure. The bill allows physicians to forego obtaining informed consent when a hysterectomy or oophorectomy is performed in a life-threatening emergency situation.

01/18/24 House: Subcommittee recommends reporting with substitute (7-Y 1-N)
01/23/24 House: Reported from Health and Human Services with substitute (20-Y 2-N)
01/30/24 House: Motion to rerefer to committee agreed to (51-Y 49-N)
01/30/24 House: VOTE: Adoption (51-Y 49-N)
01/30/24 House: Rereferred to Health and Human Services
02/13/24 House: Left in Health and Human Services

HB 257 Sickle cell anemia; prescription of opioids for pain management.

Chief patron: Mundon King

Prescription of opioids; sickle cell anemia. Exempts prescribers from certain requirements of the Prescription Monitoring Program related to prescribing opioids if the opioid is prescribed to a patient for pain management related to sickle cell anemia.

01/23/24 House: Subcommittee recommends reporting (6-Y 2-N)
01/25/24 House: Reported from Health and Human Services (15-Y 7-N)
01/31/24 House: VOTE: Passage (63-Y 35-N)

02/29/24 Senate: Reported from Education and Health (13-Y 2-N)
03/04/24 Senate: Passed Senate (39-Y 0-N)
Governor's Action Deadline 11:59 p.m., April 8, 2024

HB 324 PA Licensure Compact; authorizes Virginia to become a signatory to Compact.

Chief patron: Glass

PA Licensure Compact. Authorizes Virginia to become a signatory to the PA Licensure Compact. The Compact permits eligible physician assistants to practice in Compact-participating states, provided that they are licensed in at least one participating state. The Compact has been passed in three states and takes effect when it is enacted by a seventh participating state or upon the effective date of the bill, whichever is later.

02/07/24 House: Subcommittee recommends reporting with amendments (8-Y 0-N)
02/08/24 House: Reported from Health and Human Services with amendment(s) (22-Y 0-N)
02/13/24 House: VOTE: Block Vote Passage (99-Y 0-N)
02/20/24 Senate: Rereferred from Privileges and Elections (13-Y 1-N)
02/29/24 Senate: Reported from Education and Health (15-Y 0-N)
03/04/24 Senate: Passed Senate (33-Y 7-N)
Governor's Action Deadline 11:59 p.m., April 8, 2024

HB 371 Physicians; informed consent, procedure observation by students or trainees for teaching purposes.

Chief patron: Martinez

DEAD BILL

Physicians; informed consent; procedure observation by students or trainees for teaching purposes. Requires physicians to notify patients that students or trainees may observe a procedure and requires physicians to obtain informed consent before such observation may occur.

01/25/24 House: Subcommittee recommends reporting with substitute (5-Y 3-N)
02/01/24 House: Tabled in Health and Human Services (22-Y 0-N)

HB 480 Health care; life-sustaining treatment for minors, exceptions.

Chief patron: Scott, P.A.

DEAD BILL

Simon's Law; health care; life-sustaining treatment for minors; exceptions. Requires a physician to obtain the written permission from at least one parent or legal guardian of a minor, defined in the bill as an unemancipated individual who is younger than 18 years of age and not under juvenile court supervision or on active duty with the Armed Forces of the United States, before instituting a Do Not Resuscitate order or similar physician's order. The bill creates an exception for when a physician is unable to contact a parent or legal guardian of such minor within 72 hours of the initial contact attempt. The bill also prevents a physician from interfering with such parent's or legal guardian's efforts to obtain other medical opinions, hindering or delaying the necessary measures to facilitate a transfer of such minor to another medical facility, or refusing to continue providing life-sustaining treatment to such minor when such a transfer is imminent. Under the bill, such parent or legal guardian maintains all rights to determine whether life-sustaining treatment and cardiopulmonary resuscitation are used on such minor unless a court of law or equity determines that there is destruction of the circulatory system, respiratory system, and the entire brain. A parent or legal guardian may also request disclosure of the physician's policies involving cardiopulmonary resuscitation and life-sustaining treatment.

01/18/24 House: Subcommittee recommends reporting with substitute (7-Y 1-N)
01/30/24 House: Tabled in Health and Human Services (12-Y 10-N)

HB 519 Unprofessional conduct; disciplinary action against doctor for providing abortion care, etc.

Chief patron: Mundon King

Board of Medicine; unprofessional conduct. Prohibits the Board of Medicine from taking disciplinary action against a doctor based on the alleged provision or receipt of abortion care that is not prohibited under the laws of the Commonwealth, regardless of where such abortion care was provided or received. The bill also specifies that grounds for refusal to issue a certificate or license to any applicant or to take disciplinary action for procuring or performing an abortion apply to such action only as it is prohibited by the laws of the Commonwealth. Under

current law, such grounds for refusal or disciplinary action apply for procuring or performing a criminal abortion. This bill is identical to SB 716.

02/06/24 House: Subcommittee recommends reporting (5-Y 2-N)
02/08/24 House: Reported from Health and Human Services (13-Y 8-N)
02/13/24 House: VOTE: Passage (54-Y 45-N)
02/22/24 Senate: Reported from Education and Health (9-Y 5-N)
02/26/24 Senate: Passed Senate (21-Y 19-N)
Governor's Action Deadline 11:59 p.m., April 8, 2024

HB 664 Abortion; born alive infant, treatment and care, penalty.

Chief patron: Freitas

DEAD BILL

Abortion; born alive infant; treatment and care; penalty. Requires every health care provider licensed by the Board of Medicine who attempts to terminate a pregnancy to (i) exercise the same degree of professional skill, care, and diligence to preserve the life and health of a human infant who has been born alive following such attempt as a reasonably diligent and conscientious health care practitioner would render to any other child born alive at the same gestational age and (ii) take all reasonable steps to ensure the immediate transfer of the human infant who has been born alive to a hospital for further medical care. A health care provider who fails to comply with the requirements of the bill is guilty of a Class 4 felony and may be subject to disciplinary action by the Board. The bill also requires every hospital licensed by the Department of Health to establish a protocol for the treatment and care of a human infant who has been born alive following an attempt to terminate a pregnancy and for the immediate reporting to law enforcement of any failure to provide such required treatment and care.

02/01/24 House: Subcommittee failed to recommend reporting (3-Y 5-N)
02/13/24 House: Left in Health and Human Services

HB 699 Treatment with opioids; Board of Medicine, et al., to amend their regulations.

Chief patron: Maldonado

Board of Medicine; Board of Dentistry; Board of Optometry; Boards of Medicine and Nursing; patient counseling; treatment with opioids. Directs the Board of Medicine, the

Board of Dentistry, the Board of Optometry, and the Boards of Medicine and Nursing to amend their regulations to require the provision of certain information to patients being prescribed an opioid for the treatment of acute or chronic pain. The bill requires that the regulations include an exception to the required provision of such information for patients who are (i) in active treatment for cancer, (ii) receiving hospice care from a licensed hospice or palliative care, (iii) residents of a long-term care facility, (iv) being prescribed an opioid in the course of treatment for substance abuse or opioid dependence, or (v) receiving treatment for sickle cell disease. The bill directs the Boards to adopt emergency regulations to implement the provisions of the bill.

01/25/24 House: Subcommittee recommends reporting with amendments (8-Y 0-N)
01/30/24 House: Reported from Health and Human Services with amendment(s) (22-Y 0-N)
02/05/24 House: VOTE: Block Vote Passage (98-Y 0-N)
02/22/24 Senate: Reported from Education and Health (14-Y 0-N)
02/26/24 Senate: Passed Senate (40-Y 0-N)
Governor: Governor's Action Deadline 11:59 p.m., April 8, 2024

HB 858 Health care; decision-making, end of life, penalties.

Chief patron: Hope

DEAD BILL

Health care; decision-making; end of life; penalties. Allows an adult diagnosed with a terminal condition to request and an attending health care provider to prescribe a self-administered controlled substance for the purpose of ending the patient's life. The bill requires that a patient's request for a self-administered controlled substance to end his life must be given orally on two occasions and in writing, signed by the patient and one witness, and that the patient be given an express opportunity to rescind his request at any time. The bill makes it a Class 2 felony (i) to willfully and deliberately alter, forge, conceal, or destroy a patient's request, or rescission of request, for a self-administered controlled substance to end his life with the intent and effect of causing the patient's death; (ii) to coerce, intimidate, or exert undue influence on a patient to request a self-administered controlled substance for the purpose of ending his life or to destroy the patient's rescission of such request with the intent and effect of causing the patient's death; or (iii) to coerce, intimidate, or exert undue influence on a patient to forgo a self-administered controlled substance for the purpose of ending the patient's life. The bill also grants immunity from civil or criminal liability and professional disciplinary action to any

person who complies with the provisions of the bill and allows health care providers to refuse to participate in the provision of a self-administered controlled substance to a patient for the purpose of ending the patient's life.

02/01/24 House: Subcommittee recommends reporting (5-Y 3-N)
02/08/24 House: Reported from Health and Human Services (12-Y 10-N)
02/11/24 House: Read first time
02/12/24 House: Read second time and engrossed
02/13/24 House: Passed by for the day
02/13/24 House: No further action taken
02/13/24 House: Failed to pass in House

HB 964 Medicine, Board of; attorneys allowed to serve as executive director for the Board.

Chief patron: Willett

Board of Medicine; executive director; qualifications. Allows attorneys to serve as the executive director for the Board of Medicine. Under current law, the executive director for the Board of Medicine must be a physician.

01/25/24 House: Subcommittee recommends reporting (6-Y 2-N)
01/30/24 House: Reported from Health and Human Services (15-Y 7-N)
02/05/24 House: VOTE: Passage (71-Y 26-N)
02/22/24 Senate: Reported from Education and Health (15-Y 0-N)
02/26/24 Senate: Passed Senate (36-Y 4-N)
Governor's Action Deadline 11:59 p.m., April 8, 2024

HB 971 Nurse practitioners; patient care team provider, autonomous practice.

Chief patron: Tran

Nurse practitioners; autonomous practice. Lowers from five years to three years the amount of full-time clinical experience required before an advanced practice registered nurse may practice without a practice agreement and permits qualified nurse practitioners to attest that a nurse practitioner may be qualified to practice without a practice agreement. The bill permits advanced practice registered nurses to practice without a practice agreement when a patient care team physician is no longer able to serve if such advanced practice registered nurse provides evidence that he meets the requirements to practice without a practice agreement as

established by the bill. Finally, the bill requires the Department of Health Professions to collect data on the implementation of the bill and make such data publicly available on its website.

02/07/24 House: Subcommittee recommends reporting with substitute (8-Y 0-N)
02/08/24 House: Reported from Health and Human Services with substitute (21-Y 0-N)
02/13/24 House: VOTE: Passage (98-Y 1-N)
02/29/24 Senate: Reported from Education and Health (15-Y 0-N)
03/04/24 Senate: Passed Senate (39-Y 0-N)
Governor's Action Deadline 11:59 p.m., April 8, 2024

HB 978 Advanced practice registered nurses and licensed certified midwives; joint licensing.

Chief patron: Willett

DEAD BILL

Board of Medicine; Board of Nursing; joint licensing of advanced practice registered nurses and licensed certified midwives. Moves the professions of advanced practice registered nurses and licensed certified midwives from being licensed jointly by the Board of Medicine and the Board of Nursing to being licensed by the Board of Nursing only. This bill was identical to SB351 (Boysko).

02/07/24 House: Subcommittee recommends continuing to 2025
02/08/24 House: Continued to 2025 in Health and Human Services

HB 995 Medicine, Board of; temporary licensure of physicians licensed in a foreign country.

Chief patron: Tran

Board of Medicine; temporary licensure of physicians licensed in a foreign country. Permits the Board of Medicine to issue a provisional license to a physician licensed in a foreign country for no more than two years, then a subsequent renewable two-year license if the physician practices in a medically underserved area. After two years of practice under the renewable license in a medically underserved area, a physician licensed in a foreign country is eligible to apply for a full, unrestricted license to practice medicine. The bill specifies that eligibility for such licenses is conditional upon an applicant demonstrating certain educational and experiential qualifications to the Board and obtaining employment with a medical care

facility that provides an assessment and evaluation program for physicians licensed in a foreign country.

02/01/24 House: Subcommittee recommends reporting (8-Y 0-N)
02/06/24 House: Reported from Health and Human Services (22-Y 0-N)
02/12/24 House: VOTE: Block Vote Passage (100-Y 0-N)
02/29/24 Senate: Reported from Education and Health (15-Y 0-N)
03/04/24 Senate: Passed Senate (39-Y 0-N)
Governor's Action Deadline 11:59 p.m., April 8, 2024

HB 1278 Auricular acupuncture; use of the five needle protocol.

Chief patron: Zehr

Auricular acupuncture; use of the five needle protocol. Allows any person to engage in the five needle auricular acupuncture protocol (5NP), a standardized protocol wherein up to five needles are inserted into the external human ear to provide relief from the effects of behavioral health conditions, provided that such person (i) has appropriate training in the 5NP, including training established by the National Acupuncture Detoxification Association or equivalent certifying body; (ii) does not use any letters, words, or insignia indicating or implying that he is an acupuncturist; and (iii) makes no statement implying that his practice of the 5NP is licensed, certified, or otherwise overseen by the Commonwealth. Treatment utilizing the 5NP pursuant to this bill is strictly limited to the insertion of disposable, sterile acupuncture needles into the ear and only in compliance with the 5NP.

02/01/24 House: Subcommittee recommends reporting with substitute (8-Y 0-N)
02/06/24 House: Reported from Health and Human Services with substitute (20-Y 2-N)
02/12/24 House: VOTE: Passage (97-Y 3-N)
02/29/24 Senate: Reported from Education and Health (15-Y 0-N)
03/04/24 Senate: Passed Senate (39-Y 0-N)
Governor's Action Deadline 11:59 p.m., April 8, 2024

HB 1322 Certified registered nurse anesthetist; elimination of supervision requirement.

Chief patron: Sickles

DEAD BILL

Certified registered nurse anesthetist; elimination of supervision requirement. Eliminates the requirement that certified registered nurse anesthetists practice under the supervision of a doctor of medicine, osteopathy, podiatry, or dentistry. The bill provides that certified registered nurse anesthetists shall practice in consultation with a doctor of medicine, osteopathy, podiatry, or dentistry and in accordance with regulations jointly promulgated by the Board of Medicine and the Board of Nursing.

02/07/24 House: Subcommittee recommends reporting with substitute (5-Y 3-N)
02/08/24 House: Reported from Health and Human Services with substitute (12-Y 8-N)
02/13/24 House: VOTE: Passage (71-Y 28-N)
02/21/24 Senate: Assigned Education and Health Sub: Health Professions
02/29/24 Senate: Continued to 2025 in Education and Health (14-Y 1-N)

HB 1340 Breast implant patient decision checklist; Board of Medicine to develop.

Chief patron: Glass

DEAD BILL

Board of Medicine; breast implant patient decision checklist required. Directs the Board of Medicine to develop a patient decision checklist for procedures involving breast implants that informs patients of the potential risks of breast implants. The bill requires physicians to obtain an executed breast implant patient decision checklist from the patient before conducting any procedure that involves breast implants.

01/25/24 House: Subcommittee recommends reporting with substitute (8-Y 0-N)
01/30/24 House: Reported from Health and Human Services with substitute (22-Y 0-N)
02/02/24 House: Motion to rerefer to committee agreed to
02/02/24 House: Rereferred to Health and Human Services
02/13/24 House: Left in Health and Human Services

HB 1389 Practice of athletic training; amends definition.

Chief patron: Maldonado

Practice of athletic training; definition. Amends the definition of "practice of athletic training" to allow the practice of athletic training to be conducted in an inpatient or outpatient setting.

02/01/24 House: Subcommittee recommends reporting (8-Y 0-N)
02/06/24 House: Reported from Health and Human Services (22-Y 0-N)
02/12/24 House: VOTE: Block Vote Passage (100-Y 0-N)
02/29/24 Senate: Reported from Education and Health with amendments (15-Y 0-N)
03/04/24 Senate: Passed Senate with amendments (39-Y 0-N)
03/05/24 House: Senate amendments agreed to by House (86-Y 0-N)

SB 35 Renewal of licensure; Boards of Medicine & Nursing to require Bd. of Nursing, etc., cont. ed. reqd.

Chief patron: Locke

Board of Medicine; continuing education; unconscious bias and cultural competency. Directs the Board of Medicine to require unconscious bias and cultural competency training as part of the continuing education requirements for renewal of licensure. The bill specifies requirements for the training and requires the Board of Medicine to report on the training to the Department of Health and the Virginia Neonatal Perinatal Collaborative. This bill is identical to HB 1130.

01/25/24 Senate: Reported from Education and Health with substitute (10-Y 5-N)
01/31/24 Senate: Reported from Finance and Appropriations (15-Y 0-N)
02/05/24 Senate: Read third time and passed Senate (36-Y 4-N)
02/15/24 House: Reported from Health and Human Services (15-Y 7-N)
02/20/24 House: VOTE: Passage (57-Y 41-N)
03/08/24 Senate: Governor's recommendation received by Senate
03/08/24 Senate: Governor's substitute printed 24109174D-S2

SB 133 Physician assistants; practice agreement exemption.

Chief patron: Head

Physician assistants; practice agreement exemption. Allows physician assistants employed by a hospital or employed in certain facilities operated by the Department of Behavioral Health and Developmental Services or in federally qualified health centers designated by the Centers for Medicare and Medicaid Services to practice without a separate practice agreement if the credentialing and privileging requirements of the applicable facility include a practice arrangement, as described in the bill.

01/18/24 Senate: Reported from Education and Health (15-Y 0-N)
01/23/24 Senate: Read third time and passed Senate (39-Y 0-N)
02/15/24 House: Subcommittee recommends reporting (8-Y 0-N)
02/20/24 House: Reported from Health and Human Services (21-Y 1-N)
02/23/24 House: VOTE: Passage (97-Y 1-N)
02/28/24 Senate: Enrolled
Governor's Action Deadline 11:59 p.m., April 8, 2024

SB 237 Contraception; establishes right to obtain, applicability, enforcement.

Chief patron: Hashmi

Contraception; right to contraception; applicability; enforcement. Establishes a right to obtain contraceptives and engage in contraception, as defined in the bill. The bill creates a cause of action that may be instituted against anyone who infringes on such right. This bill is identical to HB 609.

02/08/24 Senate: Reported from Education and Health with substitute (9-Y 6-N)
02/12/24 Senate: Read third time and passed Senate (21-Y 19-N)
02/20/24 House: Subcommittee recommends reporting (6-Y 2-N)
02/22/24 House: Reported from Health and Human Services (13-Y 8-N)
02/27/24 House: VOTE: Passage (53-Y 43-N)
Governor's Action Deadline 11:59 p.m., April 8, 2024

SB 392 Hospitals; emergency departments to have at least one licensed physician on duty at all times.

Chief patron: Pekarsky

Hospitals; emergency departments; licensed physicians. Requires any hospital with an emergency department to have at least one licensed physician on duty and physically present at all times. Current law requires such hospitals to have a licensed physician on call, though not necessarily physically present on the premises, at all times. The bill has a delayed effective date of July 1, 2025.

01/25/24 Senate: Reported from Education and Health with amendment (15-Y 0-N)
01/30/24 Senate: Reported from Finance and Appropriations (15-Y 0-N)
02/02/24 Senate: Read third time and passed Senate (38-Y 0-N)
02/15/24 House: Reported from Health and Human Services with amendment(s) (21-Y 1-N)
02/20/24 House: VOTE: Passage (63-Y 36-N)
02/22/24 Senate: House amendment agreed to by Senate (36-Y 2-N)
Governor's Action Deadline 11:59 p.m., April 8, 2024

HB 120 DPOR and DHP; certain suspensions not considered disciplinary action.

Chief patron: Sullivan

Department of Professional and Occupational Regulation; Department of Health Professions; certain suspensions not considered disciplinary action. Prohibits any board of the Department of Professional and Occupational Regulation or the Department of Health Professions issuing a suspension upon any regulant of such board pursuant to such regulant's having submitted a check, money draft, or similar instrument for payment of a fee required by statute or regulation that is not honored by the bank or financial institution named from considering or describing such suspension as a disciplinary action.

01/18/24 House: Subcommittee recommends reporting (8-Y 0-N)
01/23/24 House: Reported from General Laws (21-Y 0-N)
01/30/24 House: Reported from Health and Human Services (22-Y 0-N)
02/05/24 House: VOTE: Block Vote Passage (98-Y 0-N)
02/14/24 Senate: Reported from General Laws and Technology (15-Y 0-N)
02/19/24 Senate: Passed Senate (39-Y 0-N)
03/08/24 Governor: Approved by Governor-Chapter 18 (effective 7/1/24)

HB 722 Regulatory Budget Program; established, report.

Chief patron: Webert

DEAD BILL

Department of Planning and Budget; Regulatory Budget Program established; report. Directs the Department of Planning and Budget to establish a Regulatory Budget Program under which each executive branch agency subject to the Administrative Process Act shall reduce overall regulatory requirements by 30 percent by January 1, 2027. The bill requires the Department to report to the Speaker of the House of Delegates and the Chairman of the Senate Committee on Rules on the status of the Program no later than October 1 of each year, beginning October 1, 2025. Finally, the bill provides that the Department, in consultation with the Office of the Governor, shall issue guidance for agencies regarding the Program and how an agency can comply with the requirements of the Program. The bill has an expiration date of January 1, 2027.

01/25/24 House: Subcommittee recommends striking from docket (8-Y 0-N)
01/30/24 House: Stricken from docket by General Laws (22-Y 0-N)

HB 1428 Regulatory boards; application review timelines.

Chief patron: Shin

DEAD BILL

Department of Professional and Occupational Regulation; application review timelines. Requires each regulatory board within the Department of Professional and Occupational Regulation to adopt a timeline of each stage that a completed application for licensure, certification, or registration will undergo as it is reviewed by such board. The bill also requires that such regulatory board approve any completed application within 30 days of its receipt unless such board has reasonable certainty that such application includes grounds for denial.

02/08/24 House: Subcommittee recommends striking from docket (7-Y 0-N)
02/08/24 House: Stricken from docket by General Laws (20-Y 0-N)

SB 682 Health professions; universal licensure, requirements.

Chief patron: Suetterlein

DEAD BILL

Health professions; universal licensure; requirements. Requires health regulatory boards within the Department of Health Professions to recognize licenses or certifications issued by other United States jurisdictions, as defined in the bill, as fulfillment for licensure or certification in the Commonwealth if certain conditions are met. The bill also requires such health regulatory boards to recognize work experience as fulfillment for licensure or certification in the Commonwealth if certain conditions are met. The bill does not apply to licensure for physicians or dentists.

02/08/24 Senate: Reported from Education and Health with substitute (15-Y 0-N)
02/09/24 Senate: Continued to 2025 in Rules (8-Y 6-N 1-A)

Agenda Item: Completion of periodic review of public participation guidelines contained in 18VAC85-11

Included in your agenda packet:

- Town Hall summary page showing no comments on periodic review
- 18VAC85-11

Staff Note: Agencies are required to conduct periodic reviews of regulatory chapters every four years. Although this particular chapter is only changed when the Department of Planning and Budget provides new model language, the Board was still required to conduct a periodic review. Now that the review is complete, the Board should not initiate any changes, but retain as is until DPB amends the model regulations.

Action Needed:

- Motion to retain 18VAC85-11 as is.

Agency **Department of Health Professions**

Board **Board of Medicine**

Chapter **Public Participation Guidelines [18 VAC 85 - 11]**

Edit Review

Review 2475

Periodic Review of this Chapter

Includes a Small Business Impact Review

Date Filed: 10/19/2023

Notice of Periodic Review
Pursuant to Executive Order 19 (2022) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, this regulation is undergoing a periodic review.

The review of this regulation will be guided by the principles in Executive Order 19 https://TownHall.Virginia.Gov/EO-19-Development-and-Review-of-State-Agency-Regulations.pdf.

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

In order for you to receive a response to your comment, your contact information (preferably an email address or, alternatively, a U.S. mailing address) must accompany your comment. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

Contact Information	
Name / Title:	Erin Barrett / *Director of Legislative and Regulatory Affairs*
Address:	Perimeter Center 9960 Mayland Drive, Suite 300 Henrico, VA 23233
Email Address:	erin.barrett@dhp.virginia.gov
Telephone:	(804)367-4688 FAX: (804)915-0382 TDD: ()-

Publication of Notice in the Register and Public Comment Period

Published in the Virginia Register on 11/20/2023 [Volume: 40 Issue: 7]

Comment Period begins on the publication date and ended on 12/11/2023

Comments Received: 0

Review Result

Pending

TH-07 Periodic Review Report of Findings *(not yet submitted)*

ORM Economic Review Form *(not yet submitted)*

Attorney General Certification

Submitted to OAG: 10/19/2023
Review Completed: 10/25/2023
Result: Certified

Review Memo

This periodic review was created by Erin Barrett on 10/19/2023 at 10:22am

Commonwealth of Virginia

PUBLIC PARTICIPATION GUIDELINES

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 85-11-10 et seq.

Statutory Authority: §§ 54.1-2400 and 2.2-4007 of the *Code of Virginia*

Revised Date: December 16, 2016

9960 Mayland Drive, Suite 300
Richmond, VA 23233-1463

(804) 367-4600 (TEL)
(804) 527-4426 (FAX)
email: medbd@dhp.virginia.gov

TABLE OF CONTENTS

Part I
Purpose and Definitions

18VAC85-11-10. Purpose.

The purpose of this chapter is to promote public involvement in the development, amendment or repeal of the regulations of the Board of Medicine. This chapter does not apply to regulations, guidelines, or other documents exempted or excluded from the provisions of the Administrative Process Act (§2.2-4000 et seq. of the Code of Virginia).

18VAC85-11-20. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Administrative Process Act" means Chapter 40 (§2.2-4000 et seq.) of Title 2.2 of the Code of Virginia.

"Agency" means the Board of Medicine, which is the unit of state government empowered by the agency's basic law to make regulations or decide cases. Actions specified in this chapter may be fulfilled by state employees as delegated by the agency.

"Basic law" means provisions in the Code of Virginia that delineate the basic authority and responsibilities of an agency.

"Commonwealth Calendar" means the electronic calendar for official government meetings open to the public as required by §2.2-3707 C of the Freedom of Information Act.

"Negotiated rulemaking panel" or "NRP" means an ad hoc advisory panel of interested parties established by an agency to consider issues that are controversial with the assistance of a facilitator or mediator, for the purpose of reaching a consensus in the development of a proposed regulatory action.

"Notification list" means a list used to notify persons pursuant to this chapter. Such a list may include an electronic list maintained through the Virginia Regulatory Town Hall or other list maintained by the agency.

"Open meeting" means any scheduled gathering of a unit of state government empowered by an agency's basic law to make regulations or decide cases, which is related to promulgating, amending or repealing a regulation.

"Person" means any individual, corporation, partnership, association, cooperative, limited liability company, trust, joint venture, government, political subdivision, or any other legal or commercial entity and any successor, representative, agent, agency, or instrumentality thereof.

"Public hearing" means a scheduled time at which members or staff of the agency will meet for the purpose of receiving public comment on a regulatory action.

"Regulation" means any statement of general application having the force of law, affecting the rights or conduct of any person, adopted by the agency in accordance with the authority conferred on it by applicable laws.

"Regulatory action" means the promulgation, amendment, or repeal of a regulation by the agency.

"Regulatory advisory panel" or "RAP" means a standing or ad hoc advisory panel of interested parties established by the agency for the purpose of assisting in regulatory actions.

"Town Hall" means the Virginia Regulatory Town Hall, the website operated by the Virginia Department of Planning and Budget at www.townhall.virginia.gov, which has online public comment forums and displays information about regulatory meetings and regulatory actions under consideration in Virginia and sends this information to registered public users.

"Virginia Register" means the Virginia Register of Regulations, the publication that provides official legal notice of new, amended and repealed regulations of state agencies, which is published under the provisions of Article 6 (§2.2-4031 et seq.) of the Administrative Process Act.

Part II
Notification of Interested Persons

18VAC85-11-30. Notification list.

A. The agency shall maintain a list of persons who have requested to be notified of regulatory actions being pursued by the agency.

B. Any person may request to be placed on a notification list by registering as a public user on the Town Hall or by making a request to the agency. Any person who requests to be placed on a notification list shall elect to be notified either by electronic means or through a postal carrier.

C. The agency may maintain additional lists for persons who have requested to be informed of specific regulatory issues, proposals, or actions.

D. When electronic mail is returned as undeliverable on multiple occasions at least 24 hours apart, that person may be deleted from the list. A single undeliverable message is insufficient cause to delete the person from the list.

E. When mail delivered by a postal carrier is returned as undeliverable on multiple occasions, that person may be deleted from the list.

F. The agency may periodically request those persons on the notification list to indicate their desire to either continue to be notified electronically, receive documents through a postal carrier, or be deleted from the list.

18VAC85-11-40. Information to be sent to persons on the notification list.

A. To persons electing to receive electronic notification or notification through a postal carrier as described in 18VAC85-11-30, the agency shall send the following information:

1. A notice of intended regulatory action (NOIRA).

2. A notice of the comment period on a proposed, a reproposed, or a fast-track regulation and hyperlinks to, or instructions on how to obtain, a copy of the regulation and any supporting documents.

3. A notice soliciting comment on a final regulation when the regulatory process has been extended pursuant to §2.2-4007.06 or 2.2-4013 C of the Code of Virginia.

B. The failure of any person to receive any notice or copies of any documents shall not affect the validity of any regulation or regulatory action.

Part III
Public Participation Procedures

18VAC85-11-50. Public comment.

A. In considering any nonemergency, nonexempt regulatory action, the agency shall afford interested persons an opportunity to (i) submit data, views, and arguments, either orally or in writing, to the agency; and (ii) be accompanied by and represented by counsel or other representative. Such opportunity to comment shall include an online public comment forum on the Town Hall.

1. To any requesting person, the agency shall provide copies of the statement of basis, purpose, substance, and issues; the economic impact analysis of the proposed or fast-track regulatory action; and the agency's response to public comments received.

2. The agency may begin crafting a regulatory action prior to or during any opportunities it provides to the public to submit comments.

B. The agency shall accept public comments in writing after the publication of a regulatory action in the Virginia Register as follows:

1. For a minimum of 30 calendar days following the publication of the notice of intended regulatory action (NOIRA).

2. For a minimum of 60 calendar days following the publication of a proposed regulation.

3. For a minimum of 30 calendar days following the publication of a reproposed regulation.

4. For a minimum of 30 calendar days following the publication of a final adopted regulation.

5. For a minimum of 30 calendar days following the publication of a fast-track regulation.

6. For a minimum of 21 calendar days following the publication of a notice of periodic review.

7. Not later than 21 calendar days following the publication of a petition for rulemaking.

C. The agency may determine if any of the comment periods listed in subsection B of this section shall be extended.

D. If the Governor finds that one or more changes with substantial impact have been made to a proposed regulation, he may require the agency to provide an additional 30 calendar days to solicit additional public comment on the changes in accordance with § 2.2-4013 C of the Code of Virginia.

E. The agency shall send a draft of the agency's summary description of public comment to all public commenters on the proposed regulation at least five days before final adoption of the regulation pursuant to § 2.2-4012 E of the Code of Virginia.

18VAC85-11-60. Petition for rulemaking.

A. As provided in §2.2-4007 of the Code of Virginia, any person may petition the agency to consider a regulatory action.

B. A petition shall include but is not limited to the following information:

1. The petitioner's name and contact information;

2. The substance and purpose of the rulemaking that is requested, including reference to any applicable Virginia Administrative Code sections; and

3. Reference to the legal authority of the agency to take the action requested.

C. The agency shall receive, consider and respond to a petition pursuant to §2.2-4007 and shall have the sole authority to dispose of the petition.

D. The petition shall be posted on the Town Hall and published in the Virginia Register.

E. Nothing in this chapter shall prohibit the agency from receiving information or from proceeding on its own motion for rulemaking.

18VAC85-11-70. Appointment of regulatory advisory panel.

A. The agency may appoint a regulatory advisory panel (RAP) to provide professional specialization or technical assistance when the agency determines that such expertise is necessary to address a specific regulatory issue or action or when individuals indicate an interest in working with the agency on a specific regulatory issue or action.

B. Any person may request the appointment of a RAP and request to participate in its activities. The agency shall determine when a RAP shall be appointed and the composition of the RAP.

C. A RAP may be dissolved by the agency if:

1. The proposed text of the regulation is posted on the Town Hall, published in the Virginia Register, or such other time as the agency determines is appropriate; or

2. The agency determines that the regulatory action is either exempt or excluded from the requirements of the Administrative Process Act.

18VAC85-11-80. Appointment of negotiated rulemaking panel.

A. The agency may appoint a negotiated rulemaking panel (NRP) if a regulatory action is expected to be controversial.

B. A NRP that has been appointed by the agency may be dissolved by the agency when:

1. There is no longer controversy associated with the development of the regulation;

2. The agency determines that the regulatory action is either exempt or excluded from the requirements of the Administrative Process Act; or

3. The agency determines that resolution of a controversy is unlikely.

18VAC85-11-90. Meetings.

Notice of any open meeting, including meetings of a RAP or NRP, shall be posted on the Virginia Regulatory Town Hall and Commonwealth Calendar at least seven working days prior to the date of the meeting. The exception to this requirement is any meeting held in accordance with §2.2-3707 D of the Code of Virginia allowing for contemporaneous notice to be provided to participants and the public.

18VAC85-11-100. Public hearings on regulations.

A. The agency shall indicate in its notice of intended regulatory action whether it plans to hold a public hearing following the publication of the proposed stage of the regulatory action.

B. The agency may conduct one or more public hearings during the comment period following the publication of a proposed regulatory action.

C. An agency is required to hold a public hearing following the publication of the proposed regulatory action when:

1. The agency's basic law requires the agency to hold a public hearing;

2. The Governor directs the agency to hold a public hearing; or

3. The agency receives requests for a public hearing from at least 25 persons during the public comment period following the publication of the notice of intended regulatory action.

D. Notice of any public hearing shall be posted on the Town Hall and Commonwealth Calendar at least seven working days prior to the date of the hearing. The agency shall also notify those persons who requested a hearing under subdivision C 3 of this section.

18VAC85-11-110. Periodic review of regulations.

A. The agency shall conduct a periodic review of its regulations consistent with:

1. An executive order issued by the Governor pursuant to §2.2-4017 of the Administrative Process Act to receive comment on all existing regulations as to their effectiveness, efficiency, necessity, clarity, and cost of compliance; and

2. The requirements in §2.2-4007.1 of the Administrative Process Act regarding regulatory flexibility for small businesses.

B. A periodic review may be conducted separately or in conjunction with other regulatory actions.

C. Notice of a periodic review shall be posted on the Town Hall and published in the Virginia Register.

Agenda Item: Previously posted guidance documents that do not meet the definition of "guidance document" under Va. Code 2.2-4101

Included in your agenda packet:

- Virginia Code 2.2-4101
- Guidance document 85-1: Bylaws of the Board of Medicine
- Guidance Document 85-2: Attorney General opinion on school physical exams (1986)
- Guidance Document 85-3: Bylaws for advisory boards of the Board of Medicine
- Guidance Document 85-9: Policy on USMLE step attempts
- Guidance Document 85-11: Sanction Reference Points manual
- Guidance Document 85-20: Attorney General opinion on employment of surgeon by nonprofit corporation (1992)
- Guidance Document 85-21: Attorney General opinion on employment of physician by for-profit corporation (1995)
- Guidance Document 85-26: Compliance with law for licensed midwives (list of statutory references and VDH contact)

Staff Note: Because the documents above do not meet the definition of "guidance document" in Virginia Code § 2.2-4101, these will be listed as policy documents or informational documents on the Board's website and removed from Town Hall as guidance documents.

Action Needed:

- No action needed. For informational purposes only.

Code of Virginia
Title 2.2. Administration of Government
Chapter 41. Virginia Register Act

§ 2.2-4101. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Agency" means any authority, instrumentality, officer, board, or other unit of the government of the Commonwealth with express or implied authority to issue regulations other than the General Assembly, courts, municipal corporations, counties, other local or regional governmental authorities including sanitary or other districts and joint state-federal, interstate or intermunicipal authorities, the Virginia Resources Authority, the Virginia Code Commission with respect to minor changes made under the provisions of § 30-150, and educational institutions operated by the Commonwealth with respect to regulations that pertain to (i) their academic affairs; (ii) the selection, tenure, promotion and disciplining of faculty and employees; (iii) the selection of students; and (iv) rules of conduct and disciplining of students.

"Virginia Administrative Code" means the codified publication of regulations under the provisions of Chapter 15 (§ 30-145 et seq.) of Title 30.

"Commission" means the Virginia Code Commission.

"Guidance document" means any document developed by a state agency or staff that provides information or guidance of general applicability to the staff or public to interpret or implement statutes or the agency's rules or regulations, excluding agency minutes or documents that pertain only to the internal management of agencies. Nothing in this definition shall be construed or interpreted to expand the identification or release of any document otherwise protected by law.

"Registrar" means the Registrar of Regulations employed as provided in § 2.2-4102.

"Rule" or "regulation" means any statement of general application, having the force of law, affecting the rights or conduct of any person, promulgated by an agency in accordance with the authority conferred on it by applicable basic laws.

"Virginia Register of Regulations" means the publication issued under the provisions of Article 6 (§ 2.2-4031 et seq.) of the Administrative Process Act (§ 2.2-4000 et seq.).

1973, c. 535, § 9-6.16; 1975, c. 502; 1982, c. 489; 1984, c. 5; 1985, cc. 67, 602; 1993, c. 669; 1997, cc. 11, 87; 2001, c. 844; 2019, c. 362

The chapters of the acts of assembly referenced in the historical citation at the end of this section may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

3/18/202

VIRGINIA BOARD OF MEDICINE

BYLAWS

PART I: THE BOARD

Article I – Members

The appointment and limitations of service of the members shall be in accordance with § 54.1-2911 of the Code of Virginia.

Article II - Officers of the Board

Section 1. Offices and Titles – Officers of the Board shall consist of a president, vice-president and secretary/treasurer. All shall be elected by the Board for a term of one year. The term of each office shall begin at the conclusion of the June Board meeting and end at the conclusion of the subsequent June Board meeting.

A. President: The president shall preserve order and preside at all meetings according to parliamentary rules, the Virginia Administrative Process Act, and the Virginia Freedom of Information Act. The president shall appoint the members of the Executive Committee, Credentials Committee, Finance Committee, Committee of the Joint Boards of Medicine and Nursing, and ad hoc committees of the Board. He shall sign his name as president to the certificates authorized to be signed by the president.

B. Vice President: The vice president shall act as president in the absence of the president. The vice president shall preserve order and preside at all meetings of the Legislative Committee according to parliamentary rules, the Virginia Administrative Process Act, and the Virginia Freedom of Information Act. He shall, in consultation with the president, appoint the members of the Legislative Committee and shall sign his name as vice-president to the certificates authorized to be signed by the vice-president.

C. Secretary/Treasurer: The secretary/treasurer shall be knowledgeable of budgetary and financial matters of the Board. The secretary/treasurer shall preserve order and preside at all meetings of the Finance Committee according to parliamentary rules, the Virginia Administrative Process and the Virginia Freedom of Information Act. He shall sign his name as secretary/treasurer to the certificates authorized to be signed by the secretary/treasurer.

D. The officers of the Board shall faithfully perform the duties of their offices and shall coordinate with staff regularly on matters pertaining to their offices.

E. Order of succession: In the event of a vacancy in the office of president, the vice president shall assume the office of president for the remainder of the term. In the event of a vacancy in the office of vice president, the secretary/treasurer shall assume the

office of vice president for the remainder of the term. In the event of a vacancy of the office of secretary/treasurer, the president shall appoint a Board member to fill the vacancy for the remainder of the term.

F. The Executive Director shall keep true records of all general and special acts of the Board and all documents of value. When a committee is appointed for any purpose, he shall notify each member of his appointment and furnish any essential document or information at his command. He shall conduct the correspondence of the Board when requested and shall sign certificates authorized to be issued by the Board and perform all such other duties as naturally pertain to his position.

Article III - Meetings

Section 1. Frequency of meetings: The Board shall meet at least three times a year.

Section 2. Order of Business Meetings - The order of business shall be as follows:

Call to order

Roll call

Approval of minutes of preceding regular Board meeting and any called meeting since the last regular meeting of the Board

Adoption of Agenda

Public Comment Period

Report of Officers and Executive Director:
- President
- Vice President
- Secretary/Treasurer
- Executive Director

Report of Committees:
- Executive Committee
- Legislative Committee
- Credentials Committee
- Finance Committee
- Other Standing Committees
- Ad Hoc Committees

Report of Advisory Boards
- Acupuncture
- Athletic Training
- Midwifery

Occupational Therapy
Physician Assistant
Radiological Technology
Respiratory Care
Behavior Analysis
Polysomnographic Technology
Genetic Counseling

Old Business

New Business

Election of Officers

Article IV – Committees

Section 1. Standing committees. The standing committees of the Board shall consist of the following:

Executive Committee
Legislative Committee
Credentials Committee
Finance Committee
Committee of the Joint Boards of Medicine and Nursing
Other Standing Committees

A. **Executive Committee**. The Executive Committee shall consist of the president, vice-president, the secretary-treasurer and five other members of the board appointed by the president. The Executive Committee shall include at least two citizen members. The president shall serve as chairman of the Executive Committee. In the absence of the Board, the executive committee shall have full powers to take any action and conduct any business as authorized by § 54.1-2911 of the Code of Virginia. Five members of the executive committee shall constitute a quorum.

B. **Legislative Committee**. The Legislative Committee shall consist of seven Board members appointed by the vice-president of the Board in consultation with the President. The vice president of the Board or his designee will serve as chair. The committee shall consider all questions bearing upon state and federal legislation, and regulations. The Legislative Committee shall recommend changes in the law and regulations as it may deem advisable and, at the direction of the Board, shall take such steps as may further the desire of the Board in matters of legislation and regulations. The committee shall submit proposed changes in the rules and regulations of the Board in writing to all Board members prior to any scheduled meeting of the Board.

C. **Credentials Committee**. The Credentials Committee shall consist of nine members of the Board appointed by the President and shall satisfy itself that applicants for licensure

by endorsement or by examination fulfill the requirements of the Board. The Committee shall review the credentials of the applicants who may fail to meet the requirements of the Board as specified in statute or regulation. The Committee may hear credentialing issues in accordance with §2.2-4019 and §2.2-4021 of the Code of Virginia and guidelines adopted by the Board.

D. **Finance Committee**. The Finance Committee shall consist of the secretary/treasurer, two other members appointed by the president and the Executive Director shall act ex officio to the committee. This committee shall be responsible for making recommendations to the Board regarding all financial matters. The committee shall meet as necessary.

E. **Committee of the Joint Boards of Medicine and Nursing**. The Committee shall be appointed in accordance with § 54.1-2957 of the Code of Virginia and shall function as provided in 18VAC90-30-30 of the Regulations Governing the Licensure of Nurse Practitioners.

F. Members appointed to a committee shall faithfully perform the duties assigned to the committee. Committee chairs shall regularly communicate with staff on matters pertaining to the committee.

Section 2. Ad Hoc Committees.

A. The Board or any of its standing committees may establish such ad hoc committees as are deemed necessary to assist the Board or committee in its work.

B. The members of an ad hoc committee shall be appointed by the president of the Board or the chair of the committee creating the ad hoc committee. The chair may appoint members to an ad hoc committee who are not members of the Board when it serves the purpose of the committee.

C. All members of an ad hoc committee shall have full and equal voting rights.

D. Members appointed to a committee shall faithfully perform the duties assigned to the committee. Committee chairs shall regularly communicate with staff on matters pertaining to the committee.

Article V – Elections

The Board shall appoint a Nominating Committee at its February meeting. The Nominating Committee shall present the names of candidates for office to the Board for election at its June meeting. In the event that the offices are vacated and succession is not possible, the Board shall appoint a Nominating Committee which will develop a slate of candidates for the Board's consideration at its next meeting.

Amendments to Bylaws

Amendments to these bylaws may be proposed by presenting the amendments in writing to all Board members seven calendar days prior to any scheduled Board meeting.

COMMONWEALTH of VIRGINIA

Office of the Attorney General

October 25, 1986

The Honorable Thomas W. Athey
County Attorney for York County
P. O. Box 532
Yorktown, Virginia 23690

My dear Mr. Athey:

You ask three questions regarding the meaning of the physical examination and immunization requirements for admission of students to public schools as set forth in §§ 22.1-270 and 22.1-271.2 of the Code of Virginia. More specifically, you ask:

(1) whether an individual licensed to practice chiropractic by the Virginia State Board of Medicine is a "qualified licensed physician" for purposes of performing a physical examination within the meaning of § 22.1-270(A)(i);

(2) whether such an individual is a "licensed physician" who may give a written certification that "one or more of the required immunizations may be detrimental to the student's health" as contemplated by § 22.1-271.2(C)(ii); and

(3) whether a general statement to the effect that the vaccines used for preschool immunization are contraindicated because each of the vaccines is accompanied by a listing of certain potentially harmful side effects, where the statement does not relate the general potential for harmful side effects to specific medical conditions or circumstances of the child, satisfies the requirements for an exemption from immunization which are set forth in § 22.1-271.2(C)(ii).

I. Chiropractor Is Not "Qualified Licensed Physician" for Purposes of § 22.1-270(A)(i)

Section 22.1-270(A) provides, in pertinent part:

"No pupil shall be admitted for the first time to any public kindergarten or elementary school in a school division unless such pupil shall furnish, prior to admission, (i) a report

from a qualified licensed physician of a comprehensive physical examination of a scope prescribed by the State Health Commissioner performed no earlier than twelve months prior to the date such pupil first enters such public kindergarten or elementary school or (ii) records establishing that such pupil furnished such report upon prior admission to another school or school division and providing the information contained in such report." (Emphasis added.)

No definition of the term "physician" is found in Title 22.1; however, the term is defined in § 4-2(19) as "any person duly authorized to practice medicine pursuant to the laws of Virginia," and in § 8.01-581.1 as "a person licensed to practice medicine or osteopathy in this Commonwealth pursuant to Chapter 12 (§ 54-273 et seq.) of Title 54." Section 54-273(3) defines the "practice of medicine or osteopathy" as "the prevention, diagnosis and treatment of human physical or mental ailments, conditions, diseases, pain or infirmities by any means or method."

The "practice of chiropractic" is distinguished from the practice of medicine or osteopathy in § 54-273(6) and is therein defined to mean "the adjustment of the twenty-four movable vertebrae of the spinal column, and assisting nature for the purpose of normalizing the transmission of nerve energy. It does not include the use of surgery, obstetrics, osteopathy, nor the administration nor prescribing of any drugs, medicines, serums or vaccines."

A prior Opinion holds that diagnosis is contemplated as an element of the healing arts, including chiropractic. See 1981-1982 Report of the Attorney General at 193. The extent of the examination necessary to make a diagnosis, however, was not addressed. The physical examination required by § 22.1-270 is "comprehensive" and is to be of a scope prescribed by the State Health Commissioner. The standard School Entrance Physical Examination and Immunization Certification Form MCH 213B prescribes the scope of that examination to include laboratory testing, such as urinalysis, hemoglobin and tuberculin tests, as well as the certification of the immunizations about which you inquire.

I am not aware whether the training the chiropractor in question has received would enable him to interpret the required laboratory tests. I note, however, that the second portion of the form requires the examiner to certify that the child has received a proper immunization. Because chiropractors are specifically forbidden to prescribe or administer serums or vaccines

under § 54-273(6), it is my opinion that it would be contrary to the intent of the General Assembly to allow chiropractors to certify to the administration of immunizations which they themselves are not authorized to administer.[1]

In summary, because the scope of the preschool physical examination, including the certification of immunization, exceeds those areas to which a chiropractor's scope of practice is limited by § 54-273(6), I am of the opinion that a chiropractor is not a "qualified licensed physician" as contemplated by § 22.1-270.

II. Chiropractor Is Not "Licensed Physician" as Contemplated by § 22.1-271.2(C)(ii)

Section 22.1-271.2(C)(ii) provides an exception to the immunization requirements of Art. II of Ch. 14 of Title 22.1, if "the school has written certification from a licensed physician or a local health department that one or more of the required immunizations may be detrimental to the student's health, indicating the specific nature and probable duration of the medical condition or circumstance that contraindicates immunization." (Emphasis added.)

Because, as noted above, the administration or prescription of any drugs, medicines, serums or vaccines is specifically excluded from the definition of the practice of chiropractic in § 54-273(6), it is my opinion that a chiropractor may not render a professional opinion on the possible effects of such drugs, medicines, vaccines or serums. Furthermore, because a chiropractor may testify as an expert witness in a court of law only with respect to matters within the scope of practice of chiropractic as defined in § 54-273,[2] I am also of the opinion that a chiro-

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[1]This interpretation is consistent with the language of § 8.01-401.2, which authorizes chiropractors to testify as expert witnesses in a court of law as to "etiology, diagnosis, prognosis, and disability, including anatomical, physiological, and pathological considerations within the scope of the practice of chiropractic as defined in § 54-273," but not as to other subjects of medicine. Reading §§ 8.01-401.2 and 54-273 together, the General Assembly has specifically limited the authority of chiropractors to render opinions in a court of law to matters involving the spinal column and the transmission of nerve energy.

[2]See supra note 1.

practor may not render an opinion to the State Health Department on a subject about which he may not render an opinion in a court of law. As a result, it is my opinion that the certification required by § 22.1-271.2(C)(ii) is outside the scope of the practice of chiropractic and that the "licensed physician" to which the statute refers does not include a doctor of chiropractic.

III. Statement that Specific Vaccines Are Contraindicated Because of Potential Side Effects Does Not Satisfy Requirements of § 22.1-271.2(C)(ii)

Your third question asks whether a statement by a "licensed physician" that "[t]he vaccines are specifically contraindicated because of potential allergic reactions including fever, convulsion, brain damage, encephalopathy, ataxia, hyperactivity, seizure, retardation, aseptic meningitis, hemiparesis, and death and the condition is permanent" (emphasis in original) satisfies the requirement of § 22.1-271.2(C)(ii). Because § 22.1-271(C)(ii) requires that the statement indicate "the specific nature and probable duration of the medical condition or circumstance that contraindicates immunization" (emphasis added), a statement of potential side effects, without more, is, in my opinion, insufficient to satisfy the statutory requirement.

The obvious purpose of § 22.1-271.2(C)(ii) is to exempt children from the immunization requirement when it has been demonstrated that immunization poses a higher risk to the student's health than the risk of contracting one of the diseases against which the immunization is directed. The statement proffered above is a generalization not meeting the purpose or intent of the certification requirement set forth in the statute. Accordingly, I am of the opinion that the statement is not legally sufficient.

With kindest regards, I am

Sincerely,

Mary Sue Terry
Attorney General

6:14/54-077

BYLAWS FOR

ADVISORY BOARDS OF THE BOARD OF MEDICINE

Article I - Members of the Advisory Board

The appointments and limitations of service of the members shall be in accordance with the applicable statutory provision of the advisory board governing such matters.

Article II - Officers

Section 1. Titles of Officers - The officers of the advisory board shall consist of a chairman and vice-chairman elected by the advisory board. The Executive Director of the Board of Medicine shall serve in an advisory capacity.

Section 2. Terms of Office - The chairman and vice-chairman shall serve for a one-year term and may not serve for more than two consecutive terms in each office. The election of officers shall take place at the first meeting after July 1, and officers shall assume their duties immediately thereafter.

Section 3. Duties of Officers.

(a) The chairman shall preside at all meetings when present, make such suggestions as may deem calculated to promote and facilitate its work, and discharge all other duties pertaining by law or by resolution of the advisory board. The chairman shall preserve order and conduct all proceedings according to and by parliamentary rules and demand conformity thereto on the part of the members. The chairman shall appoint all committees as needed.

The chairman shall act as liaison between the advisory board and the Board of Medicine on matters pertaining to licensing, discipline, legislation and regulation of the profession which the advisory board represents.

When a committee is appointed for any purpose, the chairman shall notify each member of the appointment and furnish any essential documents or information necessary.

(b) The vice-chairman shall preside at meetings in the absence of the chairman and shall take over the other duties of the chairman as may be made necessary by the absence of the chairman.

Article III - Meetings

Section 1. There shall be at least one meeting each year in order to elect the chairman and vice-chairman and to conduct such business as may be deemed necessary by the advisory board.

Section 2. Quorum - Three members shall constitute a quorum for transacting business.

Section 3. Order of Business - The order of business shall be as follows:

(a) Calling roll and recording names of members present
(b) Approval of minutes of preceding regular and special meetings
(c) Adoption of Agenda
(d) Public Comment Period
(e) Report of Officers
(f) Old Business
(g) New Business

The order of business may be changed at any meeting by a majority vote.

Article IV - Amendments

Amendments to these bylaws may be proposed by presenting the amendments in writing to all advisory board members prior to any scheduled advisory board meeting. If the proposed amendment receives a majority vote of the members present at that advisory board meeting, it shall be represented as a recommendation for consideration to the Board of Medicine at its next regular meeting.

Virginia Board of Medicine
Policy on USMLE Step Attempts

This document captures the position of the Board on the number of attempts that will be allowed for the Step Exams of the USMLE.

Effective July 1, 2021, the USMLE program reduced the Attempt Limit from 6 attempts to 4 attempts, including incomplete attempts, per Step. The policy change has been in effect for USMLE Step applications submitted on or after July 1, 2021. This policy change applies to all Step exams. The sole exception to the four-attempt rule is sponsorship by a state board for one additional attempt at the Step for which the examinee has failed four or more times.

At its discretion, the Board may support a one-time 5th attempt at a USMLE Step exam. Such approval will be limited to those individuals that: 1) have submitted a complete application to the Board of Medicine; 2) have previously passed all three Steps of the USMLE; 3) qualify for licensure in all ways except that the Step exam sequence took more than ten years; and 4) a passing score would bring the individual's sequence of exam scores into compliance with Board of Medicine regulation 18VAC85-20-140(E).
https://law.lis.virginia.gov/admincode/title18/agency85/chapter20/section140/

Further information on eligibility for USMLE Step exams can be accessed at:
https://www.usmle.org/bulletin-information/eligibility

Sanctioning Reference Points Instruction Manual

Board of Medicine

Guidance Document 85-11
Adopted July 2004
Revised August 2011

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June 2011

Dear Interested Parties:

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

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

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

Sincerely yours,

D. Reynolds-Cane, M.D.

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

Cordially,

Elizabeth A. Carter, Ph.D.

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

Table Of Contents

General information

Overview

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

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

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

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

Background

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

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

Goals

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

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

Methodology

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

Qualitative Analysis

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

Quantitative Analysis

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

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

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

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

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

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

Characteristics of the SRP System

Wide Sanctioning Ranges

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

Two Dimensional Sanctioning Grid

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

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

Voluntary Nature

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

Using the SRP System

Case Types Covered by the SRPs

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

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

Case Types Covered Within Worksheets

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

Worksheets Not Used in Certain Cases

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

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

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

Completing the SRP Coversheet & Worksheet

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

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

Worksheets

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

Coversheet

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

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

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

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

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

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

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

Determining a Specific Sanction

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

Expanded Sanctioning Grid Outcomes

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

Coversheet, Worksheets and Instructions

Sanctioning Reference Points Coversheet

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

Last First Title

Offense Score

Step 1: Case Circumstances (score all that apply)

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

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

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

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

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

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

Respondent Score

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

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

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

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

Sanctioning Grid

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

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

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

Impairment Worksheet

Board of Medicine
Adopted 5/11/11

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

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

Offense Score

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

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

Offense Score

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

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

Step 2: Case Circumstances (score all that apply)

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

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

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

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

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

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

Respondent Score

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

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

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

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

Sanctioning Grid

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

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

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

Patient Care Worksheet

Board of Medicine
Adopted 5/11/11

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

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

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

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

Offense Score

Step 1: Case Circumstances (score all that apply)

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

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

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

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

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

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

Respondent Score

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

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

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

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

Sanctioning Grid

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

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

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

Fraud/Unlicensed Activity Worksheet

Board of Medicine
Adopted 5/11/11

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

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

Offense Score

Respondent Score

Reviewed and reaffirmed: October 6, 2022

Virginia Board of Medicine
Guidance Document 85-20 Page 1/6

Office of the Attorney General

COMMONWEALTH of VIRGINIA
Office of the Attorney General

December 7, 1992

The Honorable Robert S. Bloxom
Member, House of Delegates
Box 27
Mappsville, Virginia 23407

My dear Delegate Bloxom:

You ask whether a proposed agreement between a hospital and an orthopedic surgeon, under which the surgeon would be employed directly by the hospital as a full-time member of its medical staff, would violate any of the provisions of Title 54.1 of the *Code of Virginia* pertaining to the practice of medicine. You also ask whether the proposed employment is prohibited by statutes pertaining to professional corporations.

I. Facts

A nonstock, nonprofit corporation operates Northampton-Accomack Memorial Hospital (the "Hospital") in Nassawaddox, Virginia. The Hospital services two Eastern Shore counties, both of which have widely dispersed populations and a relatively high percentage of patients who are indigent or whose medical services are paid for by government programs. The closest other hospitals are 75 miles to the north, in Maryland, and 55 miles to the south, across the Chesapeake Bay. You state that the Hospital's rural location has hampered its efforts to recruit physicians, particularly specialists.

Under the proposed agreement, the Hospital would employ an orthopedic surgeon, licensed by the Commonwealth to practice medicine, as a full-time member of its medical staff. This physician would be paid a salary by the Hospital. The Hospital would bill patients for the physician's services and would retain all amounts collected. The physician would be permitted to exercise independent professional judgment and would be solely responsible both for the medical care of patients and for the supervision of any "technical" employees of the Hospital who assist the physician in rendering medical services. I assume that these "technical" employees could include unlicensed individuals who administer various diagnostic tests and treatments ordered by physicians in accordance with Hospital protocols.

II. Applicable Statutes

A. Practice of Medicine

Articles 1 through 6, Chapter 29 of Title 54.1, containing §§ 54.1-2900 through 54.1-2973, define the practice of medicine and other specialties regulated by the Board of Medicine (the "Board"), establish eligibility requirements for licensure in the Commonwealth and detail the unprofessional conduct

that may subject a licensee of the Board to professional discipline. Generally, the "'[p]*ractice of medicine or osteopathic medicine*' means the prevention, diagnosis and treatment of human physical or mental ailments, conditions, diseases, pain or infirmities by any means or method." Section 54.1-2900. Section 54.1-2901(6) provides that personnel employed by a physician, to whom the physician delegates nondiscretionary duties for which the physician assumes responsibility, are expressly excluded from the definition of the practice of medicine and thus from the licensing requirements in Chapter 29. Sections 54.1-2902 and 54.1-2929 make it unlawful to practice medicine without a license.

Section 54.1-2903 defines the practice of medicine as follows:

> Any person shall be regarded as practicing the healing arts who actually engages in such practice as defined in this chapter, or who opens an office for such purpose, or who advertises or announces to the public in any manner a readiness to practice or who uses in connection with his name the words or letters "Doctor," "Dr.," "M.D.," "D.O.," "D.P.M.," "D.C.," "Healer," "Physical Therapist," "R.P.T.," "P.T.," "L.P.T.A.," "Clinical Psychologist," or any other title, word, letter or designation intending to designate or imply that he is a practitioner of the healing arts or that he is able to heal, cure or relieve those suffering from any injury, deformity or disease.

Section 54.1-2964 defines certain standards of medical practice:

> A. Any practitioner of the healing arts shall, prior to referral of a patient to any facility or entity engaged in the provision of health-related services, appliances or devices, including but not limited to physical therapy, hearing testing, or sale or fitting of hearing aids or eyeglasses provide the patient with a notice in bold print that discloses any known material financial interest of or ownership by the practitioner in such facility or entity and states that the services, appliances or devices may be available from other suppliers in the community. In making any such referral, the practitioner of the healing arts may render such recommendations as he considers appropriate, but shall advise the patient of his freedom of choice in the selection of such facility or entity. This section shall not be construed to permit any of the practices prohibited in § 54.1-2914.

Section 54.1-2914 details the grounds on which a physician may be considered guilty of unprofessional conduct. The division of fees between surgeons and other physicians is prohibited by § 54.1-2962. Section 54.1-2962.1 provides:

> No practitioner of the healing arts shall knowingly and willfully solicit or receive any remuneration directly or indirectly, in cases or in kind, in return for referring an individual or individuals to a facility or institution as defined in § 37.1-179 or a hospital as defined in § 32.1-123. The Board shall adopt regulations as necessary to carry out the provisions of this section. Such regulations shall exclude from the definition of "remuneration" any payments, business arrangements, or payment practices not prohibited by Title 42, Section 1320a-7b (b) of the United States Code, as amended, or any regulations promulgated pursuant thereto.

The federal statute to which § 54.1-2962.1 refers provides that the prohibition against receiving remuneration for patient referrals shall not apply to "any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services." 42 U.S.C. § 1320a-7b(b)(3)(B).

B. Professional Corporations

Professional corporations are organized under Chapter 7 of Title 13.1, §§ 13.1-542 through 13.1-556.

A "professional corporation" is defined in § 13.1-543(B) as

> (i) a corporation which is organized under this chapter for the sole and specific purpose of rendering professional service and which has as its shareholders only individuals who themselves are duly licensed or otherwise legally authorized within this Commonwealth to render the same professional service as the corporation; or ... (iii) a corporation which is organized under this chapter or under Chapter 10 [pertaining to nonstock corporations] of this title for the sole and specific purpose of rendering the professional services of one or more practitioners of the healing arts, licensed under the provisions of Chapter 29 of Title 54.1 ... and all of whose shares are held by or all of whose members are persons duly licensed or otherwise legally authorized to perform the services of a practitioner of the healing arts ....

Licensed professionals may organize and become shareholders in a professional corporation for pecuniary profit and may become members of a nonstock corporation for the "sole and specific purpose of rendering the same and specific professional service, subject to any laws, not inconsistent with the provisions of this chapter, which are applicable to the practice of that profession in the corporate form." Section 13.1-544.

Section 13.1-546 provides:

> No corporation organized and incorporated under this chapter may render professional services except through its officers, employees and agents who are duly licensed or otherwise legally authorized to render such professional services within this Commonwealth ....

III. "Corporate Practice of Medicine" Doctrine Precluding Hospital Corporation's Employment of Physician Not Adopted in Virginia Statute or Court Decision

The courts in a number of other states have developed what is known as the "corporate practice of medicine" doctrine, holding that, since a corporation may not lawfully practice medicine, a corporation may not employ a doctor as an agent to practice medicine for it. Under the doctrine, a physician hired by the corporation would also be unlawfully practicing medicine. *See, e.g., Dr. Allison, Dentist, Inc. v. Allison*, 360 Ill. 638, 196 N.E. 799 (1935); *Parker v. Board of Dental Examiners*, 216 Cal. 285, 14 P.2d 67 (1932); *see also Rockett v. Texas State Board of Medical Examiners*, 287 S.W.2d 190 (Tex. Civ. App. 1956). Those decisions were influenced primarily by statutory and public policy concerns that the medical community could be subject to commercial exploitation that would result in divided loyalties,

motivated by profit and improper lay control over professional decisions. These concerns generally were allayed by structuring contractual relationships in which the physician maintains an "independent contractor" status with the hospital and sole control over diagnosis and treatment of the patient. Although there is no court decision or statute in Virginia adopting the "corporate practice of medicine" doctrine,[1]

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[1]The fact that Virginia does not adhere strictly to the "corporate practice of medicine" doctrine has been recognized by the *Report of the Department of Health and the Department of Health Professions on Commercial Walk-In Medical Clinics in the Commonwealth*: "The [American Medical Association] encourages states to consider prohibitions on the 'corporate practice of medicine,' but in the view of the Task Force the use of the state's regulatory authority to restrict physicians from affiliating with commercial corporations may invite federal scrutiny under antitrust provisions of the Sherman and Federal Trade Commission Acts. In Virginia, statutes prohibiting physician practice in connection with commercial or mercantile establishments were repealed in 1986." 2 H. & S. Docs., H. Doc. No. 45, at 18 (1990 Sess.). Under one such repealed statute, § 54-278.1, it was unlawful for a physician to practice "as a lessee of any commercial or mercantile establishment." VA. CODE ANN. *id.* (Michie Repl. Vol. 1982).

Arguments favoring the existence of the "corporate practice of medicine" doctrine in Virginia are predicated only on inference. First, proponents of the doctrine infer its existence from the fact that only an individual, and not a corporation, may be licensed to practice medicine. That fact, however, does not preclude a corporation from employing a licensed individual. *See* §§ 54.1-2901, 54.1-2902.

Second, proponents of the doctrine note that § 38.2-4319(C) states: "A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law." There is, however, another explanation for this statutory language. Health maintenance organizations ("HMOs") arrange, pay for or reimburse costs of health care services for its members or enrollees. *See* § 38.2-4303. Without the exception in § 38.2-4319(C), HMO enrollees or their physicians might argue that a refusal of an HMO's agent, presumably unlicensed, to authorize reimbursement for certain medical services, such as extra days of hospitalization for a routine operation, constitutes the unlawful practice of medicine by an unlicensed person.

Third, proponents of the "corporate practice of medicine" doctrine cite § 54.1-2941, which provides express authority for state-owned medical care institutions to employ licensed practitioners, and infer from this language that other institutions may not do so. However, § 54.1-2941 was enacted before the repeal of other statutes prohibiting physician practice in commercial or mercantile establishments that might have been construed to prohibit corporate employment of physicians. Moreover, the Commonwealth may have a different relationship with patients at state institutions than private hospitals have with their patients. Without the express authority for state employment of physicians in § 54.1-2941, patients treated in state facilities might claim their physicians had a conflict of interests. This concern underscores the importance of all licensees' maintaining their independent professional judgment, whether employed in state or private institutions, but § 54.1-2941 does not preclude private hospitals from employing licensed physicians under appropriate circumstances.

Further, Virginia's professional corporation statutes, §§ 13.1-542 through 13.1-556, apply to professions in addition to those practicing the healing arts, and the availability of this corporate form has multiple purposes. It would be overreaching to conclude that the statutory framework for professional corporations precludes nonprofessional corporations from employing physicians. Indeed, other statutes illustrate the General Assembly's willingness to prohibit employment relationships for other health care professionals. *See, e.g.*, §§ 54.1-3205, 54.1-3205.1, 54.1-2716 to 54.1-2718 (expressly prohibiting commercial or mercantile employment of optometrists and dentists). If the General Assembly had intended to impose a similar prohibition on corporate employment of physicians, it could have done so in the same express manner.

many Virginia hospitals desiring to retain physicians' services have contracted with physicians as independent contractors. *See, e.g., Stuart Circle Hosp. Corp. v. Curry*, 173 Va. 136, 3 S.E.2d 153 (1939); 1954-1955 ATT'Y GEN. ANN. REP. 146.

IV. Professional Corporation Statutes Permit Properly Licensed Employee to Practice Medicine

In Virginia, a licensed professional, such as a physician, may become a member of a nonstock corporation organized to render professional services. Section 13.1-544. Such a professional corporation likewise has specific statutory authority to employ other persons licensed in the same profession to provide professional services. *See* § 13.1-546.

From the facts you provide, it is not clear whether the nonstock corporation operating the Hospital is a "professional corporation" as defined in § 13.1-543(B) or, if so, whether the physician will be a member of such a professional corporation. If those are the circumstances, the Hospital clearly has authority to employ the physician. According to a recent opinion of the Supreme Court of Virginia, however, § 13.1-546 "does not allow a professional corporation to render professional services through an independent contractor." *Palumbo v. Bennett*, 242 Va. 248, 251, 409 S.E.2d 152, 153 (1991).[2]

V. Physician May Perform Professional Services for Nonprofessional Corporation as Employee if Professional Independence Guaranteed

A prior Opinion of this Office concludes that a foundation organized as a nonstock, nonprofit corporation that has no members may employ physicians to provide medical care, and not be deemed to be practicing medicine unlawfully, as long as the physicians' exercise of professional judgment is not controlled or influenced in any way by the corporation. 1989 ATT'Y GEN. ANN. REP. 283, 285.[3]

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[2]In *Palumbo*, the Court held that, although a contract defining a physician as an independent contractor violated the statute, the contract might not be unenforceable. Although the Court recognized that "certain professionals [may] render professional services as officers, employees, or agents of a professional corporation," 242 Va. at 252, 409 S.E. 2d at 154, the Court apparently did not consider an independent contractor to be an "agent" of the professional corporation for purposes of § 13.1-546 under the facts of that case.

[3]An earlier Opinion of the Attorney General concludes that, under the medical licensure statutes in effect in 1955, a hospital which employed a physician might be engaging in the practice of medicine if there was a direct patient-physician relationship, but the hospital billed the patient for the physician's services. That Opinion further concludes that a physician having direct access to the patient should have billed that patient directly. Conversely, the hospital could bill for the services of a radiologist who provided support services for a patient, but did not have direct patient contact. That Opinion also concludes that a determination of what constitutes the practice of medicine must be made on a case-by-case basis. 1954-1955 ATT'Y GEN. ANN. REP. 146, 147. Under the current statutes, with more complex corporate structures now in use, sophisticated professional specialties, and more complicated liability issues, it is my opinion that this determination is more properly based on the physician's retention of professional judgment, rather than on the extent of his patient access or billing.

You indicate that the proposed employment agreement between the physician and the Hospital will give the physician exclusive control over decisions requiring professional medical judgment. Even though the physician is an employee of the Hospital, therefore, it is my opinion that the Hospital will not be engaging in the unlawful practice of medicine merely by paying a salary to the physician.

You also state that the proposed agreement would give the physician supervisory responsibility for unlicensed technical employees of the Hospital. Under § 54.1-2901(6), unlicensed individuals in the personal employ of a physician to whom the physician delegates nondiscretionary duties are expressly excluded from the definition of the practice of medicine. In the facts you present, however, the technical personnel would be employees of the Hospital, although supervised by the physician. Because the activities of these employees would not automatically be excluded from the definition of the practice of medicine, these unlicensed individuals must not engage in practices for which licensure is required. *See also* § 54.1-111.

VI. Conclusion

Based on the above, it is my opinion that Virginia statutes and court decisions allow the Hospital to retain the physician as an employee, as long as the agreement authorizes the physician to exercise control over the diagnosis and treatment of the patient, the physician's professional judgment is not improperly influenced by commercial or lay concerns and the physician-patient relationship is not altered.

With kindest regards, I am

Sincerely,

Mary Sue Terry
Attorney General

6:32/54-214

PROFESSIONS AND OCCUPATIONS: MEDICINE AND OTHER HEALING ARTS — PHARMACY — DRUG CONTROL ACT - PERMITTING OF PHARMACIES.

For-profit subsidiary corporations, wholly owned by general hospital operated by nonprofit tax-exempt hospital corporation, will not be engaging in unlawful practice of medicine or in unlawful practice of pharmacy by paying salaries of licensed physicians and pharmacists employed by them, as long as physicians exercise exclusive control over decisions requiring professional medical judgment, and pharmacists exercise independent professional judgment in dispensing drugs.

May 22, 1995

The Honorable Jackie T. Stump
Member, House of Delegates

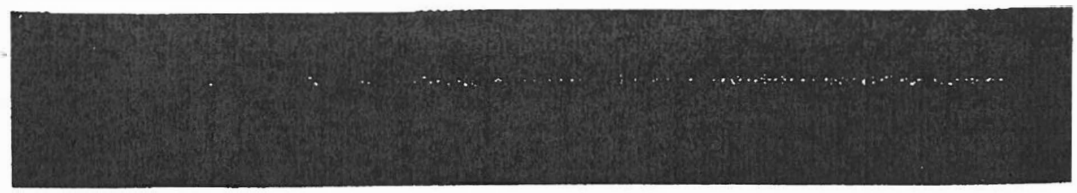
You ask whether the formation by a nonprofit, tax-exempt hospital corporation of two for-profit subsidiary corporations for the purposes of employing physicians and operating a retail pharmacy would violate any of the provisions of Title 54.1 of the *Code of Virginia* pertaining to the practice of either medicine or pharmacy.

You relate that a nonstock, nonprofit corporation operates a general hospital in Southwest Virginia. The hospital serves counties with widely dispersed populations, and a relatively high percentage of the patients in these counties are indigent or their medical services are paid by government programs. You state that efforts to recruit physicians—in particular, specialists—have been hindered due to the hospital's rural location.

Under the proposed arrangement, the hospital would form a wholly owned for-profit subsidiary corporation ("physician subsidiary") to employ one or more physicians, licensed by the Commonwealth to practice medicine, as full-time members of its medical staff. You state that the physicians would be employees of the physician subsidiary, which would be controlled by a board of directors that may consist of one or more members of the board of directors of the hospital, as well as members from the community at large. The physician subsidiary would bill patients for the physicians' services and would pay the physicians' salaries. If so directed by the board of the physician subsidiary, the hospital would receive dividends from the physician subsidiary should its revenues exceed operating costs.

Physicians employed by the physician subsidiary would exercise their independent professional judgment, and would be solely responsible for the medical care of patients and for the supervision of unlicensed technical employees administering diagnostic treatments and tests ordered by the physicians in accordance with hospital or subsidiary protocols.

You also relate that a separate for-profit subsidiary corporation ("pharmacy subsidiary") would be established to own and operate a retail pharmacy to meet the needs of



both the hospital's patients and the general public. The pharmacy subsidiary would employ a pharmacist or pharmacists, licensed by the Commonwealth, to practice pharmacy. An independent board of directors would be appointed to direct the activities of the pharmacy subsidiary, although one or more of the members also may be members of the hospital's board of directors. I assume the pharmacy subsidiary would bill patients for pharmacy services and would retain all sums collected. If so directed by the board of the pharmacy subsidiary, the hospital would receive dividends from the pharmacy subsidiary should its revenues exceed operating costs.[1]

Articles 1 through 6, Chapter 29 of Title 54.1, §§ 54.1-2900 through 54.1-2973, define the practice of medicine and other specialties regulated by the Board of Medicine, and establish eligibility requirements for licensure in the Commonwealth. Generally, "*'practice of medicine or osteopathic medicine'* means the prevention, diagnosis and treatment of human physical or mental ailments, conditions, diseases, pain or infirmities by any means or method."[2] Sections 54.1-2902 and 54.1-2929 make it unlawful to practice medicine without a license. Section 54.1-111(A)(1) also provides that it is "unlawful for any person, partnership, corporation or other entity" to practice "a profession or occupation without holding a valid license as required by statute or regulation."[3]

Prior opinions of the Attorney General conclude that a nonprofit hospital corporation and a foundation organized as a nonstock, nonprofit corporation that has no members may employ physicians to provide medical care and not be deemed to be practicing medicine unlawfully, as long as the physicians' exercise of professional judgment is not controlled or influenced in any way by the corporations.[4]

You indicate that the proposed employment arrangement between licensed physicians and the physician subsidiary will give the physicians exclusive control over decisions requiring professional medical judgment. Therefore, even though licensed physicians would be employees of the physician subsidiary, it is my opinion that the subsidiary would not be engaging in the unlawful practice of medicine merely by paying the salaries of those physicians.

Chapter 33 of Title 54.1, §§ 54.1-3300 through 54.1-3319, defines the practice of pharmacy, establishes eligibility requirements for licensure in the Commonwealth, and details unprofessional conduct that may subject a licensee of the Board of Pharmacy to discipline. Section 54.1-3300 includes the following definition:

> *"Practice of pharmacy"* means the personal health service that is concerned with the art and science of selecting, procuring, recommending, administering, preparing, compounding, packaging and dispensing of drugs, medicines and devices used in the diagnosis, treatment, or prevention of disease, whether compounded or dispensed on a prescription or otherwise legally dispensed or distributed, and shall include the proper and safe storage and distribution of drugs, the maintenance of proper records and the

responsibility of providing information concerning drugs and medicines and their therapeutic values and uses in the treatment and prevention of disease.

Section 54.1-3310 makes it unlawful to practice pharmacy without a license.

Section 54.1-3432 states that "[e]very pharmacy shall be under the personal supervision of a pharmacist on the premises of the pharmacy." In § 54.1-3434, the General Assembly expressly anticipates that a pharmacist-in-charge may be employed by a pharmacy owned by a legal corporation or partnership.[6] That section permits such an arrangement, as long as the pharmacist-in-charge applies for a permit, provides requested information and retains authority to exercise professional judgment in the dispensing of drugs.

I assume that the proposed employment arrangement between licensed pharmacists and the pharmacy subsidiary will give the pharmacists exclusive control over decisions regarding the dispensing of drugs. As long as licensed pharmacists exercise independent professional judgment in the dispensing of drugs, it is my opinion that the pharmacy subsidiary will not be engaging in the unlawful practice of pharmacy merely by paying the salaries of those pharmacists.

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[1]I assume that the factual details are such that the proposed arrangement would not violate the Practitioner Self-Referral Act, §§ 54.1-2410 through 54.1-2414, or applicable provisions of § 54.1-2962.1 (prohibiting solicitation or receipt of remuneration in return for patient referral) and § 54.1-2964 (disclosing interest or ownership in referral facilities and clinical laboratories). For the purposes of this opinion, I also assume that the facts are such that the proposed arrangement would be consistent with the physicians' obligations under § 1877 of the Social Security Act, which became effective for most purposes on January 1, 1995. *See* 42 U.S.C.A. § 1395nn (West Supp. 1995). This federal statute prohibits a physician who has a financial relationship with an entity from referring Medicare patients to the entity to receive any designated health services. *See id.* § 1395nn(a)(1)(A). A financial relationship may exist as an ownership or investment relationship or in a compensation arrangement with an entity. *See id.* § 1395nn(a)(2). Compensation arrangements exist when there is any arrangement in which payment of any kind, including a salary or consulting fee, passes between a physician or a member of the physician's immediate family and an entity, such as a hospital. *See id.* § 1395nn(h)(1).

[2]Section 54.1-2900; *see also* § 54.1-2903.

[3]Prior opinions of the Attorney General discuss in detail the statutes and court decisions pertaining to the practice of medicine. *See* Op. Va. Att'y Gen.: 1992 at 147; 1989 at 283.

[4]*See* Op. Va. Att'y Gen.: 1992, *supra*, at 150; 1989, *supra*, at 285. In Virginia, each health regulatory board has its own basic law and has developed regulations applicable to the professions it regulates. Judicial decisions that pertain to a particular health profession are appropriately based on statutes and regulations pertinent to the profession at issue. Because there are significant differences among the statutes and regulations pertaining to each health profession, judicial decisions based on a particular profession's basic law and regulations are not generalizable across professions. For example, in the case of *Virginia Beach S.P.C.A., Inc. v. South Hampton Roads Veterinary Association, et al.*, the Supreme Court of Virginia relied on specific regulations of the Virginia Board of Veterinary Medicine to conclude that an S.P.C.A.'s operation of a full-service veterinary clinic, despite employment of a fully licensed veterinarian, constituted the unlawful

practice of veterinary medicine. 229 Va. 349, 329 S.E.2d 10 (1985). These regulations prohibited the registration of any animal facility unless the owner, partner or officer of the facility was a licensed veterinarian and, further, characterized as "unprofessional conduct" the forming, entering or being employed by a partnership or corporation to practice veterinary medicine in which any other partner or corporation officer is not a licensed veterinarian. *Id.* at 352-53, 329 S.E.2d at 12. Since there are no similar statutory or regulatory provisions pertaining to the Board of Medicine or the Board of Pharmacy, the Supreme Court decision affects only the Board of Veterinary Medicine. Further, as discussed in detail in a prior opinion, statutes prohibiting physician practice in connection with commercial or mercantile establishments were repealed in 1986. *See* 1992 Op. Va. Att'y Gen., *supra* note 3, at 151 n.1; *see also* Ch. 87, 1986 Va. Acts Reg. Sess. 114.

Similarly, the Virginia Supreme Court's decision in *Ritholz v. Commonwealth* was based on statutes pertinent to the practice of optometry, and did not involve the practice of medicine or pharmacy. 184 Va. 339, 35 S.E.2d 210 (1945).

[5]Section 54.1-3434 requires that "[n]o person shall conduct a pharmacy without first obtaining a permit from the Board [of Pharmacy]." This statute requires that the application for the permit be "signed by a pharmacist who will be in full and actual charge of the pharmacy and who will be fully engaged in the practice of pharmacy at the location designated on the application." Further, § 54.1-3434 expressly anticipates that the pharmacy may have a corporate owner and requires that the pharmacist-in-charge be permitted to exercise independent professional judgment, by providing:

"The application shall show the corporate name and trade name and shall list any pharmacist in addition to the pharmacist-in-charge practicing at the location indicated on the application.

"If the owner is other than the pharmacist making the application, the type of ownership shall be indicated and shall list any partner or partners, and, if a corporation, then the corporate officers and directors. Further, if the owner is not a pharmacist, he shall not abridge the authority of the pharmacist-in-charge to exercise professional judgment relating to the dispensing of drugs in accordance with this act and Board regulations.

"The permit shall be issued only to the pharmacist who signs the application as the pharmacist-in-charge and as such assumes the full responsibilities for the legal operation of the pharmacy. This permit and responsibilities shall not be construed to negate any responsibility of any pharmacist or other person.

"Upon termination of practice by the pharmacist-in-charge, or upon any change in partnership composition, or upon the acquisition of the existing corporation by another person, the permit previously issued shall be immediately surrendered to the Board by the pharmacist-in-charge to whom it was issued, or by his legal representative, and an application for a new permit may be made ...."

Board of Medicine

Guidance Document on Compliance with Law for Licensed Midwives

The following sections of the Code of Virginia have been identified as applicable to the practice of a licensed midwife. *The listing is not intended to be all-inclusive but should be regarded as a reference for the legal responsibilities of a midwife*. Each section is listed as an electronic link to the actual language in the Code. Every licensed midwife should familiarize herself with these and any other legal responsibilities relating to her care of an expectant mother and her newborn child.

Below the listing of Code sections may be found links and contact information that may be used for additional resources on compliance with law and regulation.

§ 32.1-49. Tuberculosis required to be reported.

§ 32.1-60. Prenatal tests required.

§ 32.1-61. Definition.

§ 32.1-62. Procedure upon infant's birth.

§ 32.1-63. Duty of physician, midwife or nurse noting ophthalmia neonatorum.

§ 32.1-64.1. Virginia Hearing Loss Identification and Monitoring System.

§ 32.1-65. Certain newborn screening required.

§ 32.1-66. Commissioner to notify physicians; reports to Commissioner.

§ 32.1-73. Failure to comply with provisions; grounds for revocation of license or permit.

§ 32.1-127.1:03. Health records privacy.

§ 32.1-134.01. Certain information required for maternity patients.

§ 32.1-257. Filing birth certificates; from whom required; signatures of parents.

§ 32.1-257.1. Parents to report social security account number at time of child's birth.

§ 32.1-264. Reports of fetal deaths; medical certification; investigation by medical examiner; confidentiality of information concerning abortions.

§ 32.1-285.1. Death of infants under eighteen months of age; autopsies required; definition of Sudden Infant Death Syndrome.

§ 54.1-2403.01. Routine component of prenatal care.

§ 54.1-2403.02. Prenatal education; cord blood banking.

§ 54.1-2403.1. Protocol for certain medical history screening required.

§ 63.2-1509. Requirement that certain injuries to children be reported by physicians, nurses, teachers, etc.; penalty for failure to report.

For additional information or guidance on compliance with law in Chapter 32.1 of the Code of Virginia, contact: Cornelia Deagle, VDH's Director of the Division of Child and Family Health, at cornelia.deagle@vdh.virginia.gov or (804) 864-7691.

You may access further information and additional resources at:
http://www.vdh.virginia.gov/vdhlivewell/women/ and
http://www.vdh.virginia.gov/vdhlivewell/infants-children-and-teens/.

Next Meeting Date of the Executive Committee is

August 2, 2024

Please check your calendars and advise staff of any known conflicts that may affect your attendance.

The travel regulations require that "travelers must submit the Travel Expense Reimbursement Voucher **within 30 days after completion of their trip"**. (CAPP Topic 20335, State Travel Regulations, p.7). Vouchers submitted after the 30-day deadline can not be approved.

In order for the agency to be in compliance with the travel regulations, please submit your request for today's meeting on or before

May 5, 2024