Legislative Committee Meeting

Virginia Board of Medicine

September 7, 2018

8:30 a.m.

Legislative Committee

Virginia Board of Medicine
Friday, September 7, 2018, 8:30 a.m.
9960 Mayland Drive, Suite 200
Board Room 4
Henrico, VA 23233

PUBLIC COMMENT

Proposed Amendments to Regulations – Licensed Midwives and Physician Assistants

Page

Call to Order – Ray Tuck, DC, Chair

Roll Call

Adoption of Agenda

Public Comment on Agenda Items (15 minutes)

New Business

Announcements

Next Meeting: January 11, 2019

Adjournment

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

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Board Room 4

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VIRGINIA BOARD OF MEDICINE
LEGISLATIVE COMMITTEE MINUTES

Friday, January 19, 2018 | Department of Health Professions | Henrico, VA

CALL TO ORDER: The meeting convened at 8:37 a.m.

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

MEMBERS PRESENT:
Ray Tuck, DC, Vice-President, Chair
Barbara Allison-Bryan, MD
David Giammittorio, MD
Jane Hickey, JD
David Taminger, MD
Svinder Toor, MD

MEMBERS ABSENT: Isaac Koziol, MD

STAFF PRESENT:
William L. Harp, MD, Executive Director
Jennifer Deschenes, JD, Deputy Director, Discipline
Alan Heaberlin, Deputy Director, Licensure
Barbara Matusiak, MD, Medical Review Coordinator
Colanthia Morton Opher, Operations Manager
Elaine Yeatts, DHP Senior Policy Analyst
Erin Barrett, JD, Assistant Attorney General
Sherry Gibson, Administrative Assistant

OTHERS PRESENT:
Ryan LaMura, VHHA
Ajay Manhapra, MD, Hampton VA Medical Center
Tiffany Dews, Sickle Cell Chapter of Richmond
Julie Galloway, MSV
George Harris, Statewide Sickle Cell Chapters of VA
Dionne Bobo, Statewide Sickle Cell Chapters of VA

EMERGENCY EGRESS INSTRUCTIONS

Dr. Allison-Bryan provided the emergency egress instructions.

APPROVAL OF MINUTES OF MAY 19, 2017

Ms. Hickey moved to approve the meeting minutes of May 19, 2017. The motion was seconded and carried unanimously.

ADOPTION OF AGENDA

Dr. Allison-Bryan moved to accept the agenda as presented. The motion was seconded and carried unanimously.

PUBLIC COMMENT

Dionne BoBo addressed the Committee saying that she has two children who have sickle cell disease. She asked the Committee to consider adding an exemption in the proposed opioid regulations to ensure that prescribers that treat patients with sickle cell disease know that they can provide adequate doses of opioids to control the pain.

Tiffany Dews, with Statewide Sickle Cell Chapters of Virginia and mother of two children with sickle cell, asked the Committee to exempt this population from the opioid regulations.

George Carter, with Statewide Sickle Cell Chapters of Virginia, requested an amendment to 18VAC85-21-10(B) that would include a fourth exception to the guidelines for "patients diagnosed with Sickle Cell Disease".

Ajay Manhapra, MD provided his perspective regarding the difficulty of opioid tapering in high-dose patients. He stated that restricting the writing of opioid prescriptions is not the solution and that the other side of this action is an alarming rate of suicide. Dr. Manhapra said that the policy seems based on feelings and not science. Regarding buprenorphine, it is not a detox medication or substitute therapy. The principle is that buprenorphine saves lives, and the lack of buprenorphine does not. He quoted a recent study that showed the use of buprenorphine mono-product nationwide was 8.8%. He asked the Committee to consider convening an ad hoc committee to look at the regulations again before going forward.

Julie Galloway expressed MSV's support for the existing emergency regulations.

The floor closed at 8:56 a.m.

DHP DIRECTOR'S REPORT

No report.

EXECUTIVE DIRECTOR'S REPORT

No report.

NEW BUSINESS

1. Report from the General Assembly

Elaine Yeatts distributed the most current report from the 2018 Session of the General Assembly and reviewed the bills that were of interest to the Committee. This report was for informational purposes only. No action was required.

2. Chart of Board of Medicine Regulatory Actions

Elaine Yeatts provided a brief overview of the Board's ongoing regulatory activity. She noted that the comment period on the proposed regulations for the prescribing of opioids and buprenorphine ends on January 26, 2018.

3. Review of Comments/Discussion of proposed regulations for opioid prescribing

Ms. Yeatts presented the proposed regulations. She noted that the major change from the initial emergency regulations was to incorporate the language below into the amended emergency regulations signed by Gov. McAuliffe August 24, 2017. The language below was presented to the Committee in the proposed regulations for consideration.

For patients who have a demonstrated intolerance to naloxone; such prescriptions for the mono-product shall not exceed 3.0% of the total prescriptions for buprenorphine written by the prescriber, and the exception shall be clearly documented in the patient's medical record.

Dr. Allison-Bryan noted that there was no language in the regulations about tapering or inpatient treatment. She noted that the amended emergency regulations do not limit the prescriber in terms of appropriate doses, and perhaps the regulations are being misunderstood. Now may be the Board's opportunity to reach out to prescribers and provide factual reassurance to those that have become reluctant to treat patients with adequate doses.

Dr. Harp stated that, based on the e-mail inquiries and phone calls he has received, a significant number of physicians have not read the regulations.

Dr. Toor agreed that sickle cell disease is like cancer; it is a chronic and deep wound pain that is not visible from the outside. In pediatric sickle cell patients, opioids are used very liberally, but that is only one part of the treatment. He feels that it would be reasonable to add sickle cell disease as an exemption, so the patients can receive proper care.

Ms. Deschenes said that public comment regarding the inclusion of an exemption for sickle cell disease was brought to the attention of the Executive Committee and discussed; however, the debate came down to, although sickle cell disease is an example of pain that requires large doses of opioids, so do many other diseases. How would the Board keep from expanding the list of such diseases/conditions? The fact remains that the practitioner needs to read and understand the regulations.

In response to Dr. Allison-Bryan's inquiry about how 3% became the threshold for total mono-product prescriptions, Ms. Yeatts advised that the Board considered 5%, which was intended to include patients with financial issues. However, the Board agreed to leave the financial piece out of the regulations, so the 3% is strictly for those that have documented naloxone intolerance.

Dr. Harp pointed out that half of the experts on the Regulatory Advisory Panel that practice medication-assisted treatment with buprenorphine did not believe in naloxone intolerance; the other half did. He said he found little information in the literature about naloxone intolerance to report to the May 2017 Legislative Committee, so it decided on 3%.

Ms. Yeatts then noted that a large number of people on treatment for chronic pain are financially strapped by the requirement for urine drug screens. The current regulations require drugs screens 2-4 times per year. She suggested looking to the Centers for Disease Control (CDC) guidelines for a different standard.

Dr. Allison-Bryan referred to page 73 of the CDC guidelines. CDC recommends that, in the context of chronic pain, clinicians should order urine drug testing before starting opioid therapy and consider urine drug testing at least annually. Such testing is to check for compliance with the prescribed regimen, other prescribed medications, and illicit drugs. Dr. Allison-Bryan said that screens are extremely helpful in disciplinary hearings. She noted that there are inexpensive screens that provide qualitative results. She believes there is still much prescriber education to be done.

Dr. Toor noted that CDC has no data to show drug testing is helpful. He thinks it should be done when the prescriber thinks it is needed. There should be some degree of freedom for those that are doing a good job. Not everyone should suffer for the mismanagement of the few.

Dr. Harp added that, anecdotally, buprenorphine + naloxone is abused as is the mono-product. A Richmond area organization that educates teenagers about drug abuse says that buprenorphine + naloxone is the most abused opioid by the youth they serve.

After discussion, the Committee agreed on the following recommendations to the Board:

- 18VAC85-21-10(B)(1) – shall read: The treatment of acute or chronic pain related to (i) cancer, (ii) sickle cell disease, (iii) a patient in hospice care, or (iv) a patient in palliative care.

- Although it is difficult to pinpoint a percentage of patients that demonstrate naloxone intolerance, the rate allowed by the regulations should be increased to 7%. Dr. Harp stated that the increase is justified based on clinical comments to the Board.

- Drug screens should be conducted initially and then randomly at the prescriber's discretion, at least once a year.

- Insert (atypical opioid) after tramadol, where applicable, in acute pain, chronic pain and buprenorphine. This should decrease the confusion that tramadol is not considered an opioid.

4. **Proposed Consent Order**

Ms. Deschenes and Caroline McNichol presented a Consent Order for reinstatement of a physician's license. Dr. Allison-Bryan moved to accept the Consent Order as presented. The motion was seconded and carried unanimously.

5. **Reminder:** Dr. Tuck reminded the Committee members to submit their travel expense reimbursement vouchers by February 19, 2018.

ANNOUNCEMENTS

There were no additional announcements.

Next meeting – May 18, 2018

Adjournment - With no other business to conduct, the meeting adjourned at 10:45 a.m.

Ray Tuck, Jr., DC
Vice-President, Chair

William L. Harp, MD
Executive Director

Colanthia Morton Opher, Operations Manager
Recording Secretary

Agenda Item: Review of Guidance Documents

Included in your agenda package:

Listing of guidance documents for the Board with those that have not been reviewed, revised or readopted in the past four years highlighted.

Documents to be reviewed

Staff note:

A preliminary review has been conducted by staff and recommendations are included on the listing and the documents

Committee action: Recommend retention, revision, or repeal to the full Board at its October meeting

BOARD OF MEDICINE GUIDANCE DOCUMENTS

STAFF RECOMMENDATIONS

Copies of the following documents may be viewed during regular workdays from 8:15 a.m. until 5 p.m. at the offices of the Department of Health Professions, 9960 Mayland Drive, Suite 300, Henrico, VA 23233. Copies may also be downloaded from the board's web page at http://www.dhp.virginia.gov/medicine or the Regulatory Town Hall at http://www.townhall.virginia.gov or requested by email at medbd@dhp.virginia.gov. Questions regarding interpretation or implementation of these documents or requests for copies may be directed to William L. Harp, M.D., Executive Director of the Board, at the address above or by telephone at (804) 367-4600. Copies are free of charge.

Guidance Documents:

http://www.dhp.virginia.gov/medicine/medicine_guidelines.htm

85-1, Bylaws of the Board of Medicine, revised June 14, 2018

85-2, Assistant Attorney General Opinion of October 25, 1986 on who can do a school physical examination **Recommendation: Retain**

85-3, Completing Form B, Employment Verification, adopted December 1, 2017

85-4, Acceptance of Providers of Approved Continuing Education (PACE) for chiropractic CE, adopted February 19, 2015

85-5, Guidance of questions concerning medical records, revised August 10, 2017

85-6, Guidance on competency assessments for three paid claims, revised July 2, 2011 **Recommendation: Reaffirm**

85-8, Authority for physician assistants to write Do Not Resuscitate Orders, adopted February 23, 2012 **Recommendation: Reaffirm**

85-9, Policy on USMLE Step attempts, adopted October 24, 2013 **Recommendation: Reaffirm**

85-10, High-risk pregnancy disclosures for licensed midwives, revised October 22, 2015

85-11, Sanctioning Reference Points Instruction Manual, revised by Board, August 2011

85-12, Telemedicine, revised June 22, 2017 **Recommendation: Revise**

85-13, Board motion, Guidelines on Performing Procedures on the Newly Deceased for Training Purposes, January 22, 2004 **Recommendation: Revise**

85-14, Procedure for enforcement of continuing competency requirements, adopted June 18, 2015

85-15, Board motion, Guidelines Concerning the Ethical Practice of Surgery and Invasive Procedures, January 22, 2004 **Recommendation: Revise**

85-16, Questions and Answers on Continuing Competency Requirements for the Virginia Board of Medicine, revised December 3, 2007 **Recommendation: Revise**

85-17, Guidance on supervisory responsibilities of an occupational therapist, adopted February 15, 2018

85-18, Practitioners' Help Section. - Definitions and explanations for terminology used in Practitioner Profile System and Frequently Asked Questions, revised November 22, 2010 **Recommendation: Repeal**

85-19, Practitioner Information System - Glossary of Terms, revised November 22, 2010 **Recommendation: Reaffirm**

85-20, Official Opinion of the Attorney General, December 1992 on employment of surgeon by a nonstock, nonprofit corporation **Recommendation: Retain**

85-21, Official Opinion of the Attorney General, May 1995 on employment of physician by a for profit corporation **Recommendation: Retain**

85-23, Policy of the Virginia Board of Medicine on the Use of Confidential Consent Agreements, October 9, 2003 **Recommendation: Revise**

85-24, Board motion, Adoption of FSMB Model Policy for the Use of Controlled Substances for the Treatment of Pain, revised October 24, 2013 **Recommendation: Repeal**

85-25, Board motion, Process for Delegation of Informal Fact-finding to an Agency Subordinate, October 14, 2004 **Recommendation: Repeal**

85-26, Laws Pertaining to the Practice of Licensed Midwives, revised June 20, 2013 **Recommendation: Revise**

85-27, Role of Licensed Midwives in Newborn Hearing Screening, Documentation, and Reporting, revised June 20, 2013 **Recommendation:**

85-28, Authority for licensed midwives to order tests, revised October 26, 2017

COMMONWEALTH of VIRGINIA

Office of the Attorney General

Mary Sue Terry
Attorney General

Lane Kneedler
Chief Deputy Attorney General

R. Claire Guthrie
Deputy Attorney General
Natural Resources Div.

Jan Starling Marshall
Deputy Attorney General
Judicial Affairs Division

Walter A. McFarlane
Deputy Attorney General
Finance & Transportation Div.

Stephen D. Rosenthal
Deputy Attorney General
Criminal Law Enforcement Div.

Deborah Love-Bryant
Executive Assistant

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

Guidance document: 85-6 Revised: July 2, 2011

GUIDANCE DOCUMENT OF THE VIRGINIA BOARD OF MEDICINE

COMPETENCY ASSESSMENTS FOR THREE PAID CLAIMS

In 2005 the General Assembly passed law to require competency assessments for licensees with three medical malpractice claims (judgments or settlements) paid in the most recent ten-year period. The original law was amended in 2007 and again in 2011. It is found in Section 54.1-2912.3 of the Code of Virginia and now reads as follows:

§ 54.1-2912.3. Competency assessments of certain practitioners.

The Board shall require an assessment of the competency of any person holding an active license under this chapter on whose behalf three separate medical malpractice judgments or medical malpractice settlements of more than $75,000 each are paid within the most recent 10-year period. The assessment shall be accomplished in 18 months or less by a program acceptable to the Board. The licensee shall bear all costs of the assessment. The results of the assessment shall be reviewed by the Board and the Board shall determine a plan of corrective action or appropriate resolution pursuant to the assessment. The assessment, related documents and the processes shall be governed by the confidentiality provisions of § 54.1-2400.2 and shall not be admissible into evidence in any medical malpractice action involving the licensee. The Board shall annually post the number of competency assessments undertaken on its website.

(2005, cc. 649, 692; 2007, c. 861; 2011, c. 808.)

In the implementation of the initial law, it was determined that at least one of the paid claims must have occurred on or after July 1, 2005.

Identification of Licensees Subject to the Law

The Data Division of the Department of Health Professions will proactively identify the licensees that appear to have three medical malpractice judgments or settlements of more than $75,000 in the most recent ten-year period by searching the Board of Medicine's Physician Profiles on a quarterly basis. Identification of individuals subject to this law may also occur through the review of other data held by the Board.

Notification of Subject Licensees

Licensees that appear to be subject to this law will be sent a letter by certified mail apprising them of their responsibility to obtain a competency assessment. If a licensee believes that he/she has received the letter in error, or needs further clarification regarding the assessment, he/she is instructed to call the Board.

Process of Obtaining a Competency Assessment

It is the responsibility of the subject licensee to make the arrangements for the assessment. The Board has determined that a licensee may obtain a competency assessment from one of the national programs that conduct such assessments. The list includes, but is not limited to, the Federation of State Medical Boards Post-Licensure Assessment Program and the Center for Personalized Education for Physicians.

The Board has also determined that a subject licensee may obtain the competency assessment with a medical school faculty member of the same specialty. Should the licensee choose this approach, the following steps should be followed.

1) Contact the appropriate department of the medical school where the assessment will be sought.
2) Identify a faculty member (evaluator) of the same specialty that is willing to perform the assessment.
3) With the evaluator, prepare an outline of the proposed approach to the assessment. The evaluator has the latitude to determine the format of the assessment. At a minimum, the paid claims that triggered the assessment should be discussed, as well as matters pertinent to an assessment of global competency to practice. This would include a subject licensee's fund of knowledge, medical judgment and in a procedural specialty, skills. The assessment can include more elements if deemed necessary by the parties.
4) Send the outline of the proposed assessment to the Executive Director for approval prior to proceeding.
5) After receiving approval, proceed with the assessment.
6) Provide the evaluator with all documents required by the approved outline. The Board will not provide information to the evaluator.
7) Provide the evaluator with a written release of liability for the assessment and report to the Board.
8) Ensure that the evaluator sends the report of the competency assessment to the Board.
9) Compensate the evaluator for his/her time.

Completion of Assessment and Report to the Board

1) The assessment must be completed within 18 months of the Board's notification to the licensee.

2) The Board will review the report of the assessment and communicate its recommendations to the subject licensee. The Board may choose to close the matter or require further assessment. While the competency assessment is, in and of itself, not a disciplinary matter for the licensee, it is possible that the assessment could lead to the initiation of a disciplinary process.

3) The competency assessment and the process are confidential pursuant to § 54.1-2400.2 of the Code of Virginia. However, if matter becomes disciplinary, Notices and Orders associated with the process will be public.

Guidance document: 85-6 Revised: July 2, 2011

Virginia Board of Medicine
Competency Assessment Form

Please ask the evaluator to print/type the requested information.

Doctor to be evaluated: _____

Virginia License Number: _____

Evaluator: _____

Evaluator's Address: _____

_____

Evaluator's Telephone Number: _____

Evaluator's Email Address: _____

Date(s) of face to face meeting(s): _____

1. **Review of the facts regarding the paid claim cases:**

   The evaluator may request the doctor provide him with any documentation necessary to assist in the competency assessment which may include:

   - Complaint or motion for the Judgment
   - Answer or Grounds of Defense
   - Medical Records, including relevant radiology images
   - Expert Witness Designations
   - Deposition Transcripts of all Parties and expert Witnesses
   - Court Orders
   - Settlement Agreements
   - Lessons learned, risk management and practice changes

   (attach additional sheets as necessary)

2. **Describe this doctor's fund of knowledge, medical judgment or decision-making and in the case of procedural specialties, skills.**

   The evaluator may request:

   - Board certification information
   - CME records
   - Other educational information. *(attach additional sheets as necessary)*

3. **Doctor's strengths:**

4. **Doctor's weaknesses:**

5. **Is there a need for remediation?**

6. **Is this doctor safe to practice?**

Evaluator Signature Date:

Please return to the attention of Dr. Harp at
Virginia Board of Medicine
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Guidance Document: 85-8 Adopted: 2/23/12

Board of Medicine

Authority of Physician Assistants to write Do Not Resuscitate Orders (DNR Orders)

In the Health Care Decisions Act (§ 54.1-2981 et seq. of the Code of Virginia), § 54.1-2987.1 provides that a Durable Do Not Resuscitate Order may be issued by a physician. § 54.1-2952.2 provides that, "Whenever any law or regulation requires a signature…by a physician, it shall be deemed to include a signature…by a physician assistant."

Therefore, the Board of Medicine concurs that licensed physician assistants have the statutory and regulatory authority to write Do Not Resuscitate Orders in accordance with §§ 54.1-2952.2 and 54.1-2987.1 of the Code of Virginia and 18VAC85-50-101 of the Virginia Administrative Code.

The authority for a physician assistant to write DNR orders must be included in the written protocol as a delegated act by the supervising physician and must be performed in consultation with the physician.

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.

The following is the response to an inquiry of NBME regarding its policy for the number of attempts allowed for each Step Exam of the USMLE.

"The USMLE Program announced in August 2011that it was introducing a limit on the total number of times an examinee can take the same Step or Step Component. Effective January 1, 2013, an examinee is ineligible to take a Step or Step Component if the examinee has made six or more prior attempts to pass that Step or Step Component, including incomplete attempts. All attempts at a Step or Step Component are counted toward the limit, regardless of when the exams were taken. The sole exception to this policy allows a state medical board to request an additional administration in unique and specific cases in which the board feels strongly about doing so on behalf of an individual with a nexus to the state who would be eligible for licensure in that state if he/she passed USMLE. You may ask a state medical board (such as that in the state where you reside or have some other compelling connection), which is fully aware of your complete testing history, to petition the USMLE program to grant you an additional attempt."

At its .February 21, 2013 meeting, the Board of Medicine indicated its concurrence with the recommendation to limit attempts at Step 3 to six, and directed staff to indicate to those that inquired that it was Board policy not to authorize extra attempts at Step 3.

At its October 24, 2013 meeting, the Board reviewed the NBME policy statement above and indicated its concurrence, to include all four exams in the Step sequence. Staff is directed to inform those who inquire that it is policy of the Board of Medicine that additional attempts past six are not be authorized for any Step Exam.

Virginia Board of Medicine

Telemedicine

Section One: Preamble.

The Virginia Board of Medicine ("Board") recognizes that using telemedicine services in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these services can enhance medical care by facilitating communication between practitioners, other health care providers, and their patients, prescribing medication, medication management, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice. With the exception of prescribing controlled substances, the Virginia General Assembly has not established statutory parameters regarding the provision and delivery of telemedicine services. Therefore, practitioners must apply existing laws and regulations to the provision of telemedicine services. The Board issues this guidance document to assist practitioners with the application of current laws to telemedicine service practices.

These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method used to enable practitioner-to-patient communications. For the purpose of prescribing controlled substances, a practitioner using telemedicine services in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the practitioner-patient relationship as defined in Virginia Code § 54.1-3303. A practitioner should conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine services as a component of, or in lieu of, in-person provision of medical care, while others are not. The practitioner is responsible for making this determination, and in doing so must adhere to applicable laws and standards of care.

The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine services in the practice of medicine. The Board is committed to ensuring patient access to the convenience and benefits afforded by telemedicine services, while promoting the responsible provision of health care services.

It is the expectation of the Board that practitioners who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;
- Adhere to recognized ethical codes governing the applicable profession;
- Adhere to applicable laws and regulations;

- In the case of physicians, properly supervise non-physician clinicians when required to do so by statute; and
- Protect patient confidentiality.

Section Two: Establishing the Practitioner-Patient Relationship.

The practitioner-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that practitioners recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a practitioner-patient relationship. Where an existing practitioner-patient relationship is not present,[1] a practitioner must take appropriate steps to establish a practitioner-patient relationship consistent with the guidelines identified in this document, with Virginia law, and with any other applicable law.[2] While each circumstance is unique, such practitioner-patient relationships may be established using telemedicine services provided the standard of care is met.

A practitioner is discouraged from rendering medical advice and/or care using telemedicine services without (1) fully verifying and authenticating the location and, to the extent possible, confirming the identity of the requesting patient; (2) disclosing and validating the practitioner's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine services. An appropriate practitioner-patient relationship has not been established when the identity of the practitioner may be unknown to the patient.

Section Three: Guidelines for the Appropriate Use of Telemedicine Services.
The Board has adopted the following guidelines for practitioners utilizing telemedicine services in the delivery of patient care, regardless of an existing practitioner-patient relationship prior to an encounter.

Licensure:

The practice of medicine occurs where the patient is located at the time telemedicine services are used, and insurers may issue reimbursements based on where the practitioner is located. Therefore, a practitioner must be licensed by, or under the jurisdiction of, the regulatory board of the state where the patient is located and the state where the practitioner is located. Practitioners who treat or prescribe through online service sites must possess appropriate licensure in all jurisdictions where patients receive care. To ensure appropriate insurance coverage, practitioners must make certain that they are compliant with federal and state laws and policies regarding reimbursements.

Evaluation and Treatment of the Patient:

[1] This guidance document is not intended to address existing patient-practitioner relationships established through in-person visits.

[2] The practitioner must adhere not only to Virginia law defining a practitioner-patient relationship, but the law in any state where a patient is receiving services that defines the practitioner-patient relationship.

A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, which treatment includes the issuance of prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional, in-person encounters. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

Informed Consent:

Evidence documenting appropriate patient informed consent for the use of telemedicine services must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following:

- Identification of the patient, the practitioner, and the practitioner's credentials;
- Types of activities permitted using telemedicine services (e.g. prescription refills, appointment scheduling, patient education, etc.);
- Agreement by the patient that it is the role of the practitioner to determine whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine services, such as encrypting date of service, password protected screen savers, encrypting data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.

Medical Records:

The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-practitioner communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine services. Informed consents obtained in connection with an encounter involving telemedicine services should also be filed in the medical record. The patient record established during the use of telemedicine services must be accessible to both the practitioner and the patient, and consistent with all established laws and regulations governing patient healthcare records.

Privacy and Security of Patient Records and Exchange of Information:

Written policies and procedures should be maintained for documentation, maintenance, and transmission of the records of encounters using telemedicine services. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the practitioner addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication,

such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Section Four: Prescribing:

Prescribing controlled substances requires the establishment of a bona fide practitioner-patient relationship in accordance with § 54.1-3303 (A) of the Code of Virginia. Prescribing controlled substances, in-person or via telemedicine services, is at the professional discretion of the prescribing practitioner. The indication, appropriateness, and safety considerations for each prescription provided via telemedicine services must be evaluated by the practitioner in accordance with applicable law and current standards of practice and consequently carries the same professional accountability as prescriptions delivered during an in-person encounter. Where such measures are upheld, and the appropriate clinical consideration is carried out and documented, the practitioner may exercise their judgment and prescribe controlled substances as part of telemedicine encounters in accordance with applicable state and federal law.

Prescriptions must comply with the requirements set out in Virginia Code §§ 54.1-3408.01 and 54.1-3303(A). Prescribing controlled substances in Schedule II through V via telemedicine also requires compliance with federal rules for the practice of telemedicine. Practitioners issuing prescriptions as part of telemedicine services should include direct contact for the prescriber or the prescriber's agent on the prescription. This direct contact information ensures ease of access by pharmacists to clarify prescription orders, and further facilitates the prescriber-patient-pharmacist relationship.

For the purpose of prescribing Schedule VI controlled substances, "telemedicine services" is defined as it is in § 38.2-3418.16 of the Code of Virginia. Under that definition, *"telemedicine services," as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient or consulting with other health care providers regarding a patient's diagnosis or treatment. "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.*

Section Five: Guidance Document Limitations.

Nothing in this document shall be construed to limit the authority of the Board to investigate, discipline, or regulate its licensees pursuant to applicable Virginia statutes and regulations. Additionally, nothing in this document shall be construed to limit the Board's ability to review the delivery or use of telemedicine services by its licensees for adherence to the standard of care and compliance with the requirements set forth in the laws and regulations of the Commonwealth of Virginia. Furthermore, this document does not limit the Board's ability to determine that certain situations fail to meet the standard of care or standards set forth in laws and regulations despite technical adherence to the guidance produced herein.

Statutory references:

§ 54.1-3303. Prescriptions to be issued and drugs to be dispensed for medical or therapeutic purposes only.

A. A prescription for a controlled substance may be issued only by a practitioner of medicine, osteopathy, podiatry, dentistry or veterinary medicine who is authorized to prescribe controlled substances, or by a licensed nurse practitioner pursuant to § 54.1-2957.01, a licensed physician assistant pursuant to § 54.1-2952.1, or a TPA-certified optometrist pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32. The prescription shall be issued for a medicinal or therapeutic purpose and may be issued only to persons or animals with whom the practitioner has a bona fide practitioner-patient relationship.

For purposes of this section, a bona fide practitioner-patient-pharmacist relationship is one in which a practitioner prescribes, and a pharmacist dispenses, controlled substances in good faith to his patient for a medicinal or therapeutic purpose within the course of his professional practice. In addition, a bona fide practitioner-patient relationship means that the practitioner shall (i) ensure that a medical or drug history is obtained; (ii) provide information to the patient about the benefits and risks of the drug being prescribed; (iii) perform or have performed an appropriate examination of the patient, either physically or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically; except for medical emergencies, the examination of the patient shall have been performed by the practitioner himself, within the group in which he practices, or by a consulting practitioner prior to issuing a prescription; and (iv) initiate additional interventions and follow-up care, if necessary, especially if a prescribed drug may have serious side effects. A practitioner who performs or has performed an appropriate examination of the patient required pursuant to clause (iii), either physically or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically, for the purpose of establishing a bona fide practitioner-patient relationship, may prescribe Schedule II through VI controlled substances to the patient, provided that the prescribing of such Schedule II through V controlled substance is in compliance with federal requirements for the practice of telemedicine.

For the purpose of prescribing a Schedule VI controlled substance to a patient via telemedicine services as defined in § 38.2-3418.16, a prescriber may establish a bona fide practitioner-patient relationship by an examination through face-to-face interactive, two-way, real-time communications services or store-and-forward technologies[3] when all of the following conditions are met: (a) the patient has provided a medical history that is available for review by the prescriber; (b) the prescriber obtains an updated medical history at the time of prescribing; (c) the prescriber makes a diagnosis at the time of prescribing; (d) the prescriber conforms to the standard of care expected of in-person care as appropriate to the patient's age and presenting condition, including when the standard of care requires the use of diagnostic testing and performance of a physical examination, which may be carried out through the use of peripheral devices appropriate to the patient's condition; (e) the prescriber is actively licensed in the Commonwealth and authorized to prescribe; (f) if the patient is a member or enrollee of a health plan or carrier, the prescriber has been credentialed by the health plan or carrier as a participating provider and

[3] Although the term "store-and-forward technologies" is not defined by statute, it is defined by regulation of the Virginia Department of Health for the purpose of Medicare and Medicaid covered services, as: "'store and forward' means when prerecorded images, such as x-rays, video clips, and photographs are captured and then forwarded to and retrieved, viewed, and assessed by a provider at a later time. Some common applications include (i) teledermatology, where digital pictures of a skin problem are transmitted and assessed by a dermatologist; (ii) teleradiology, where x-ray images are sent to and read by a radiologist; and (iii) teleretinal imaging, where images are sent to and evaluated by an ophthalmologist to assess for diabetic retinopathy." 12 VAC 30-121-70(7)(a).

the diagnosing and prescribing meets the qualifications for reimbursement by the health plan or carrier pursuant to § 38.2-3418.16; and (g) upon request, the prescriber provides patient records in a timely manner in accordance with the provisions of § 32.1-127.1:03 and all other state and federal laws and regulations. Nothing in this paragraph shall permit a prescriber to establish a bona fide practitioner-patient relationship for the purpose of prescribing a Schedule VI controlled substance when the standard of care dictates that an in-person physical examination is necessary for diagnosis. Nothing in this paragraph shall apply to: (1) a prescriber providing on-call coverage per an agreement with another prescriber or his prescriber's professional entity or employer; (2) a prescriber consulting with another prescriber regarding a patient's care; or (3) orders of prescribers for hospital out-patients or in-patients.

Any practitioner who prescribes any controlled substance with the knowledge that the controlled substance will be used otherwise than medicinally or for therapeutic purposes shall be subject to the criminal penalties provided in § 18.2-248 for violations of the provisions of law relating to the distribution or possession of controlled substances.

§ 54.1-3408.01. Requirements for prescriptions.

A. The written prescription referred to in § 54.1-3408 shall be written with ink or individually typed or printed. The prescription shall contain the name, address, and telephone number of the prescriber. A prescription for a controlled substance other than one controlled in Schedule VI shall also contain the federal controlled substances registration number assigned to the prescriber. The prescriber's information shall be either preprinted upon the prescription blank, electronically printed, typewritten, rubber stamped, or printed by hand.

The written prescription shall contain the first and last name of the patient for whom the drug is prescribed. The address of the patient shall either be placed upon the written prescription by the prescriber or his agent, or by the dispenser of the prescription. If not otherwise prohibited by law, the dispenser may record the address of the patient in an electronic prescription dispensing record for that patient in lieu of recording it on the prescription. Each written prescription shall be dated as of, and signed by the prescriber on, the day when issued. The prescription may be prepared by an agent for the prescriber's signature.

This section shall not prohibit a prescriber from using preprinted prescriptions for drugs classified in Schedule VI if all requirements concerning dates, signatures, and other information specified above are otherwise fulfilled.

No written prescription order form shall include more than one prescription. However, this provision shall not apply (i) to prescriptions written as chart orders for patients in hospitals and long-term-care facilities, patients receiving home infusion services or hospice patients, or (ii) to a prescription ordered through a pharmacy operated by or for the Department of Corrections or the Department of Juvenile Justice, the central pharmacy of the Department of Health, or the central outpatient pharmacy operated by the Department of Behavioral Health and Developmental Services; or (iii) to prescriptions written for patients residing in adult and juvenile detention centers, local or regional jails, or work release centers operated by the Department of Corrections.

B. Prescribers' orders, whether written as chart orders or prescriptions, for Schedules II, III, IV, and V controlled drugs to be administered to (i) patients or residents of long-term care facilities served by a Virginia pharmacy from a remote location or (ii) patients receiving parenteral, intravenous, intramuscular, subcutaneous or intraspinal infusion therapy and served by a home infusion pharmacy from a remote location, may be transmitted to that remote pharmacy by an electronic communications

device over telephone lines which send the exact image to the receiver in hard copy form, and such facsimile copy shall be treated as a valid original prescription order. If the order is for a radiopharmaceutical, a physician authorized by state or federal law to possess and administer medical radioactive materials may authorize a nuclear medicine technologist to transmit a prescriber's verbal or written orders for radiopharmaceuticals.

C. The oral prescription referred to in § 54.1-3408 shall be transmitted to the pharmacy of the patient's choice by the prescriber or his authorized agent. For the purposes of this section, an authorized agent of the prescriber shall be an employee of the prescriber who is under his immediate and personal supervision, or if not an employee, an individual who holds a valid license allowing the administration or dispensing of drugs and who is specifically directed by the prescriber.

Virginia Board of Medicine

Guidelines on Performing Procedures on the Newly Deceased for Training Purposes

Section 54.1-2961 of the Code of Virginia provides:

E. The Board of Medicine shall adopt guidelines concerning the ethical practice of physicians practicing in emergency rooms, surgeons, and interns and residents practicing in hospitals, particularly hospital emergency rooms, or other organizations operating graduate medical education programs. These guidelines shall not be construed to be or to establish standards of care or to be regulations and shall be exempt from the requirements of the Administrative Process Act (§ 2.2-4000 et seq.). The Medical College of Virginia of Virginia Commonwealth University, the University of Virginia School of Medicine, the Eastern Virginia Medical School, the Medical Society of Virginia, and the Virginia Hospital and Health Care Association shall cooperate with the Board in the development of these guidelines.

The guidelines shall include, but need not be limited to (i) the obtaining of informed consent from all patients or from the next of kin or legally authorized representative, to the extent practical under the circumstances in which medical care is being rendered, when the patient is incapable of making an informed decision, after such patients or other persons have been informed as to which physicians, residents, or interns will perform the surgery or other invasive procedure; (ii) except in emergencies and other unavoidable situations, the need, consistent with the informed consent, for an attending physician to be present during the surgery or other invasive procedure; (iii) policies to avoid situations, unless the circumstances fall within an exception in the Board's guidelines or the policies of the relevant hospital, medical school or other organization operating the graduate medical education program, in which a surgeon, intern or resident represents that he will perform a surgery or other invasive procedure that he then fails to perform; and (iv) policies addressing informed consent and the ethics of appropriate care of patients in emergency rooms. Such policies shall take into consideration the nonbinding ban developed by the American Medical Association in 2000 on using newly dead patients as training subjects without the consent of the next of kin or other legal representative to extent practical under the circumstances in which medical care is being rendered.

Therefore, as guidance to its licensees, the Virginia Board of Medicine has endorsed the ethical guideline on performing procedures on the newly deceased for training purposes adopted by the American Medical Association in June, 2001, as follows:

"Physicians should work to develop institutional policies that address the practice of performing procedures on the newly deceased for purposes of training. Any such policy should ensure that the interests of all the parties involved are respected under established and clear ethical guidelines. Such policies should consider rights of patients and their families, benefits to trainees and society, as well as potential harm to the ethical sensitivities of trainees, and risks to staff, the institution and the profession associated with performing procedures on the newly deceased without consent. The following considerations should be addressed before medical trainees perform procedures on the newly deceased:

(1) The teaching of life-saving skills should be the culmination of a structured training sequence, rather than relying on random opportunities. Training should be performed

under close supervision, in a manner and environment that takes into account the wishes and values of all involved parties.
(2) Physicians should inquire whether the deceased individual had expressed preferences regarding handling of the body or procedures performed after death. In the absence of previously expressed preferences, physicians should obtain permission from the family before performing such procedures. When reasonable efforts to discover previously expressed preferences of the deceased or to find someone with authority to grant permission for the procedure have failed, physicians must not perform procedures for training purposes on the newly deceased patient.

In the event post-mortem procedures are undertaken on the newly deceased, they must be recorded in the medical record."[1]

[1] American Medical Association, Council on Ethical and Judicial Affairs, Code of Medical Ethics, Opinion 8.181, "Performing Procedures on the Newly Deceased for Training Purposes," adopted June 2001.

Guidelines Concerning the Ethical Practice of Attending Physicians and Fellows, Residents and Interns

Explanation of the nature and risk of an operation to the patient or to the patient's representative is essential.

Before surgery or an invasive procedure is performed, informed consent should be obtained from the patient in accordance with the policies of the health care entity. Patients should understand the indications for the surgery or invasive procedure, the risk involved, and the result that is hoped to be attained. In the instance of a minor or a patient who is incapable of making an informed decision on his own behalf or is incapable of communicating such a decision due to a physical or mental disorder, the legally authorized person available to give consent should be informed and the consent of the person documented. An exception to the requirement for consent prior to or during the performance of surgery or an invasive procedure may be made if a delay in obtaining consent would likely result in imminent harm to the patient.

Under the usual and customary arrangement with patients, and with reference to the usual form of consent to surgery or an invasive procedure, it is the attending physician to whom the patient grants consent and who is obligated to perform the surgery or invasive procedure. With the consent of the patient or another legally authorized person available to give consent, it is ethical for the attending physician to delegate the performance of some or all aspects of the surgery or invasive procedure to the fellow, resident, intern or assistant provided this is done under the physician's supervision as described in the supervising policy of the Accreditation Council for Graduate Medical Education (ACGME). If some or all of the surgery or procedure is to be delegated to another health care provider or if care of the patient is to be turned over to another attending physician, the patient or the legally authorized person available to give consent is entitled to be so informed and to give documented consent.

It is unethical to mislead a patient as to the identity of the doctor who performs the surgery or invasive procedure. If the identified attending physician cannot perform the surgery or invasive procedure due to any unusual or emergency reasons, the patient or another legally authorized person available to give consent must be fully informed and given another opportunity to accept or reject the replacement physician.

Supervision of trainees (fellows, residents and interns) by attending physicians

The attending physician has both an ethical and a professional responsibility for the overall care of the individual patient and for the supervision of any trainee involved in the care of the patient. Although senior trainees require less direction than their junior counterparts, even the most senior ~~must~~ should be supervised. A chain of command that emphasizes graded authority and increasing responsibility as experience is gained ~~must~~ should be established.

Judgments on this delegation of responsibility ~~must~~ should be made by the attending physician who is ultimately responsible for the patient's care; such judgments ~~shall~~ should be based on the attending physician's direct observation and knowledge of each trainee's skills and ability.

To ensure the fulfillment of these responsibilities, the following principles of supervision ~~must~~ should be operative within a training program.

1. Supervision of trainees ~~must~~ should be specified in the bylaws, policies, procedures, rules and/or regulations of the department which ~~must~~ should not be less demanding that those of the institution.
2. Evidence that adequate supervision exists within a program ~~must~~ should be provided in the form of signed notes in the patient charts and/or other such records.
3. Proper supervision ~~must~~ should not conflict with progressively more independent decision-making on the part of the trainee; thus, the degree of supervision may vary with the clinical circumstances and the training level of the trainee. However, to exercise their responsibilities properly, members of the teaching staff always ~~must~~ should be immediately available for consultation and support.

For the purposes of this guidance document, "invasive procedure" shall mean any diagnostic or therapeutic procedure performed on a patient that is not part of routine, general care and for which the usual practice within the institution is to document specific informed consent from the patient or surrogate decision-maker prior to proceeding.

Revised:

Questions and Answers on Continuing Competency Requirements for the Virginia Board of Medicine

1. **When must I have the required number of continuing competency hours completed in order to renew my license?**

   In your birth month in even years. You will be required to sign a certification on your renewal form that you have met the continuing competency requirements. Falsification on the renewal form is a violation of law and may subject you to disciplinary action.

2. **Am I required to send in evidence of my continuing competency hours at the time I renew?**

   No. The Board will randomly select licensees for a post-renewal audit. If selected, you would be notified by mail that documentation is required and given a time frame within which to comply.

3. **When do the continuing competency requirements begin?**

   Hours must be obtained within the two years immediately preceding renewal. You may not count any hours obtained prior to 24 months preceding renewal nor may you carry over excess hours to the following biennium.

4. **Who maintains the required documents for verification of continuing competency? Hours?**

   It is the practitioner's responsibility to maintain the certificates and any other continuing competency forms or records for six years following renewal ~~in 2002 and thereafter~~. Do not send any forms or documents to the Board of Medicine unless requested to do so.

5. **What are "Type 1" hours?**

   Type 1 hours (at least 30 each biennium) are those that can be documented by an accredited sponsor or organization sanctioned by the profession. If the sponsoring organization does not award a participant with a dated certificate indicating the activity or course taken and the number of hours earned, the practitioner is responsible for obtaining a letter on organizational letterhead verifying the hours and activity. All 60 continuing competency hours each biennium may be Type 1 hours.

6. **What are "Type 2" hours?**

   Type 2 hours (no more than 30 each biennium) are those earned in self-study, attending professionally related meetings, research and writing for a journal, learning a new procedure, sitting with the hospital ethics panel, etc. They are activities chosen by the practitioner based on assessment of his/her practice. They do not have to be sponsored by an accrediting organization, but must be recorded by the practitioner on the form provided by the Board.

7. **Where do I obtain the instructions and forms for continuing competency requirements?**

   Forms and instructions can be downloaded from the Board's website at: www.dhp.virginia.gov/medicine/medicine_forms.htm. Records may be maintained electronically, but

copies of documentation and forms will be necessary if a practitioner is audited following a renewal cycle. Forms may also be copied.

8. **Is it possible for a practitioner to earn accredited hours that are sanctioned by the profession but are outside the specialty area in which he/she practices?**

   Yes. For example, a pediatrician or a surgeon could receive credit for documented hours sponsored by the American Academy of Family Practice.

9. **What if I have earned the AMA Physician Recognition Award or have been recertified by my specialty board? Would that count for my continuing competency hours?**

   Yes. Provided the Board has documented proof that the requirements to obtain the AMA award (or other similar awards) or specialty board certification are equal to or exceed those required for renewal of licensure. It would only be necessary to submit evidence of having such an award or certification.

10. **What if I am newly licensed? Do I still have to obtain the full 60 hours of continued competency?**

    No. There is an exemption for those persons and for anyone practicing solely without pay in a practice (free clinic, rescue squad, etc.) that is under the direction of a fully licensed physician.

11. **What if I become ill or incapacitated and unable to complete my continuing competency requirements prior to renewal?**

    Upon written request from the practitioner explaining the circumstances, the Board may grant an extension or exemption for all or part of the required hours.

12. **What if I am now retired and don't want to obtain continuing competency hours but don't want to give up my license?**

    You may request an inactive license from the Board, beginning with your next renewal. It is important to note that **holding an inactive license does not authorize anyone to engage in the practice of medicine, osteopathy, podiatry or chiropractic in Virginia.** If you intend to practice at all in Virginia, even on a part-time or non-compensatory basis, you must retain your active license.

13. **What happens if I take inactive licensure status and later decide to reactivate?**

    A practitioner seeking to reactivate a license must pay the active renewal fee and obtain the number of hours which would have be required for the years in which the license was inactive (not to exceed four years). If the practitioner has not been engaged in active practice for more than four years, he/she must pass a special purpose examination in his area of licensure.

Revised:

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6. **What are "Type 2" hours?**

   Type 2 hours (no more than 30 each biennium) are those earned in self-study, attending professionally related meetings, research and writing for a journal, learning a new procedure, sitting with the hospital ethics panel, etc. They are activities chosen by the practitioner based on assessment of his/her practice. They do not have to be sponsored by an accrediting organization, but must be recorded by the practitioner on the form provided by the Board.

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   Yes. Provided the Board has documented proof that the requirements to obtain the AMA award (or other similar awards) or specialty board certification are equal to or exceed those required for renewal of licensure. It would only be necessary to submit evidence of having such an award or certification.

10. **What if I am newly licensed? Do I still have to obtain the full 60 hours of continued competency?**

    No. There is an exemption for those persons and for anyone practicing solely without pay in a practice (free clinic, rescue squad, etc.) that is under the direction of a fully licensed physician.

11. **What if I become ill or incapacitated and unable to complete my continuing competency requirements prior to renewal?**

    Upon written request from the practitioner explaining the circumstances, the Board may grant an extension or exemption for all or part of the required hours.

12. **What if I am now retired and don't want to obtain continuing competency hours but don't want to give up my license?**

    You may request an inactive license from the Board, beginning with your next renewal. It is important to note that **holding an inactive license does not authorize anyone to engage in the practice of medicine, osteopathy, podiatry or chiropractic in Virginia.** If you intend to practice at all in Virginia, even on a part-time or non-compensatory basis, you must retain your active license.

13. **What happens if I take inactive licensure status and later decide to reactivate?**

    A practitioner seeking to reactivate a license must pay the active renewal fee and obtain the number of hours which would have be required for the years in which the license was inactive (not to exceed four years). If the practitioner has not been engaged in active practice for more than four years, he/she must pass a special purpose examination in his area of licensure.

Practitioner's Help Section

Active License: Licensee may practice medicine, osteopathic medicine, or podiatry in Virginia.

Address of Record: The address that the licensee provides the Board to receive official communication including renewal of license, licenses, notices, or other essential written communication. This address is not subject to public disclosure under the Freedom of Information Act and will not be sold or distributed for any other purpose.

Administrative Proceeding: Pursuant to the Virginia law, an informal conference or formal hearing in order to adjudicate a matter before the Board. (See §§ 2.2-4019 and 2.2-4020, and Chapter 29 of Title 54 of the Code of Virginia).

Admitting Privileges: The level of privilege that allows the licensee to admit patients under his or her care at that particular hospital.

Board Certified: Licensee has met the requirements for certification as defined by the American Board of Medical Specialties (AMBS), the Bureau of Osteopathic Specialists of the American Osteopathic Association (AOA), the American Board of Multiple Specialties in Podiatry (ABMSP), or the Council on Podiatric Medical Education of the American Podiatric Medical Association. Certification status can be checked on medical doctors and doctors of osteopathy through the ABMS website www.abms.org "Who's Certified" or verbal verification is available through the ABMS toll-free telephone service, 1-866-ASK-ABMS. The AOA lists doctors of osteopathy that have attained certification. If you wish to contact the AOA you can visit their website: www.osteopathic.org or call them at 800-621-1773. The Council on Podiatric Medical Education of the American Podiatric Medical Association recognizes board certification from the American Board of Podiatric Surgery and the American Board of Podiatric Orthopedics and Primary Podiatric Medicine. You can contact the American Board of Podiatric Orthopedics and Primary Podiatric Medicine at their website www.abpoppm.org or at 310-891-0100 to find out if a podiatrist is certified. Certification status can be checked on podiatrists through the American Board of Multiple Specialties in Podiatry online at www.abmsp.org or if you wish verbal confirmation, call 1-888-852-1422. The ABMSP offers this service free of charge.

Conclusions of Law: A determination by the Board about whether a practitioner violated the law and/or regulation.

Continuing Education: The additional training the licensee pursues. TYPE I (accredited, sponsored activities) and TYPE II (self-study, teaching, non-approved courses, presentations, conferences). Beginning with 2002 renewals, 60 hours are required. A minimum of thirty of those hours must be TYPE I.

E-mail: For Help with the Website - **info@vahealthprovider.com**

Emergency Contact Information: The law requires an email address and fax number be provided, if available. This information will be used solely for the rapid dissemination of information to doctors in the event of a public health emergency; it is not for release to the public. As with all aspects of the profile, this information must be updated within thirty days of any change.

Fax: 804-527-4461 Attn: Data Call Center

Findings of Fact: The facts as determined by the Board pursuant to the evidence and testimony presented at the administrative proceeding or as agreed to in a consent order.

Formal Hearing: A "trial-like" proceeding at which the Board receives evidence and testimony regarding allegations of possible violations (See §§ 2.2-4020 and 54.1-2920 of the Code for Virginia). The practitioner may or may not appear at the hearing.

Hospital Affiliations: Any type of current relationship a licensee has with a hospital either as an employee (W2 form), independent contractor (1099 form), or via type of privilege, not limited to but including Courtesy, Locum tenens, Admitting, Emeritus, Honorary, Temporary, etc. The definition of the various categories of privilege varies from hospital to hospital.

Inactive License: Licensee may not practice medicine, osteopathic medicine, or podiatry in Virginia. Licensee pays a reduced renewal fee; however, the licensee is exempt from complying with the Continuing Education requirements

Informal conference: A fact-finding meeting between an Informal Conference Committee of the Board and a practitioner regarding allegations made by the Board. (See §§ 2.2-4019 and 54.1-2400 (10) of the Code of Virginia). The practitioner may or may not actually appear before the Committee.

Judgment: In the context of a malpractice claim, a judgment is an award by a court, with or without a jury, to the plaintiff, in response to a lawsuit.

Law: Laws for the Physician Profile System are found in the *Code of Virginia* as follows:

§54.1-2910.1. Certain data required.

A. The Board of Medicine shall require all doctors of medicine, osteopathy and podiatry to report and shall make available the following information:

1. The names of the schools of medicine, osteopathy, or podiatry and the years of graduation;

2. Any graduate medical, osteopathic, or podiatric education at any institution approved by the Accreditation Council for Graduation Medical Education, the American Osteopathic Association or the Council on Podiatric Medical Education;

3. Any specialty board certification as approved by the American Board of Medical Specialties, the Bureau of Osteopathic Specialists of the American Osteopathic Association, the American Board of Multiple Specialties in Podiatry, or the Council on Podiatric Medical Education of the American Podiatric Medical Association;

4. The number of years in active, clinical practice as specified by regulations of the Board;

5. Any hospital affiliations;

6. Any appointments, within the most recent 10-year period, of the doctor to the faculty of a school of medicine, osteopathy or podiatry and any publications in peer-reviewed literature within the most recent five-year period and as specified by regulations of the Board;

7. The location and telephone number of any primary and secondary practice settings and the approximate percentage of the doctor's time spent practicing in each setting. For the sole purpose of expedited dissemination of information about a public health emergency, the doctor shall also provide to the Board any e-mail address or facsimile number; however, such e-mail address or facsimile number shall not be published on the profile database and shall not be released or made available for any other purpose;

8. The access to any translating service provided to the primary and secondary practice settings of the doctor;

9. The status of the doctor's participation in the Virginia Medicaid Program;

10. Any final disciplinary or other action required to be reported to the Board by health care institutions, other practitioners, insurance companies, health maintenance organizations, and professional organizations pursuant to §§ 54.1-2400.6, 54.1-2908, and 54.1-2909 that results in a suspension or revocation of privileges or the termination of employment or a final order of the Board relating to disciplinary action;

11. Conviction of any felony; and

12. Other information related to the competency of doctors of medicine, osteopathy, and podiatry, as specified in the regulations of the Board.

B. In addition, the Board shall provide for voluntary reporting of insurance plans accepted and managed care plans in which the doctor participates.

C. The Board shall promulgate regulations to implement the provisions of this section, including, but not limited to, the release, upon request from a consumer, of such information relating to a specific doctor. The Board's regulations shall provide for reports to include all medical malpractice judgments and medical malpractice settlements of more than $10,000 within the most recent 10-year period in categories indicating the level of significance of each award or settlement; however, the specific numeric values of reported paid claims shall not be released in any individually identifiable manner under any circumstances. Notwithstanding this subsection, a licensee shall report a medical malpractice judgment or medical malpractice settlement of less than $10,000 if any other medical malpractice judgment or medical malpractice settlement has been paid by or for the licensee within the preceding 12 months.

D. This section shall not apply to any person licensed pursuant to §§ 54.1-2928.1, 54.1-2933.1, 54.1-2936, and 54.1-2937 or to any person holding an inactive license to practice medicine, osteopathy, or podiatry.

(1998, c. 744; 1999, c. 573; 2000, c. 199; 2001, c. 199; 2001, Sp. Sess. I, c. 5; 2002, c. 38; 2004, cc. 64, 703; 2007, c. 861; 2008, c. 479.)

Legal Documentation: A name change requires a copy of the court order indicating the name change, marriage certificate, divorce decree, a letter from your lawyer, or a letter from the Social Security office.

Mail: Board of Medicine's mailing address:

Virginia Board of Medicine
ATTN: Data Call Center
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Medicare Participating Provider: A licensee who contractually accepts the participating provider fee schedule.

Notices or Statement of Particulars: Documents issued by the Board alleging violations of law or regulation by a practitioner and scheduling a meeting with the Board or a Committee of the Board to resolve the allegations. Notices and Statement of Particulars describe *possible* violations. They are public documents and followed by an Order or decision letter disposing of the allegations.

Optional Data Elements: These elements are not required by law or regulations but may enhance your profile. These elements include:

Continuing Education
Days of Week at Practice Locations
E-mail Address
FAX number at Practice Locations
Health Insurance Plans/Managed Care Plans Accepted
Honors and Awards
Maiden name
Medicare participation
Security Verification
Website Address

Order: The document issued by the Board of Medicine indicating the Board's decision that the practitioner, as a matter of past or present fact, is or is not in violation of law or regulation. Typically, an order resolves the allegations in the Notice, and contains findings of fact and conclusions of law. It may impose a sanction or require some action by the practitioner. In some cases, the Board's decision is to dismiss the allegations in the Notice and such a decision is usually stated in a letter. "Order" also applies to "Consent Orders" which are agreed to by the practitioner, often without a meeting with the Board. Orders and letters containing the Board's resolution of allegations are public documents and copies are available.

Paid Claim: In the context of malpractice, a paid claim is a payment made to a person in response to a claim. It may be in the form of a "judgment" or "settlement."

Peer-Reviewed Literature: A journal or publication whose articles are reviewed and selected by an editorial board comprised of individuals having attained similar certification, education, training, and experience.

Practice Address: A location where the licensee engages in practice of medicine, osteopathic medicine, or podiatry regardless if patients are seen. Practitioners may designate a primary practice address and additional practice addresses.

Probation: A status whereby a practitioner maintains his license but must comply with the terms and conditions required by the Board. The conditions may restrict the practice.

Regulation: Rules adopted by the Board to implement the Law. Regulations pertaining to the Physician Profile are:

18VAC85-20-280. Required information.
A. In compliance with requirements of §54.1-2910.1 of the Code of Virginia, a doctor of medicine, osteopathic medicine, or podiatry licensed by the board shall provide, upon initial request or whenever there is a change in the information that has been entered on the profile, the following information within 30 days:
1. The address and telephone number of the primary practice setting and all secondary practice settings with the percentage of time spent at each location;
2. Names of medical, osteopathic or podiatry schools and graduate medical or podiatric education programs attended with dates of graduation or completion of training;
3. Names and dates of specialty board certification, if any, as approved by the American Board of Medical Specialties, the Bureau of Osteopathic Specialists of the American Osteopathic Association or the Council on Podiatric Medical Education of the American Podiatric Medical Association;
4. Number of years in active, clinical practice in the United States or Canada following completion of medical or podiatric training and the number of years, if any, in active, clinical practice outside the United States or Canada;
5. The specialty, if any, in which the physician or podiatrist practices;
6. Names of hospitals with which the physician or podiatrist is affiliated;
7. Appointments within the past 10 years to medical or podiatry school faculties with the years of service and academic rank;
8. Publications, not to exceed 10 in number, in peer-reviewed literature within the most recent five-year period;
9. Whether there is access to translating services for non-English speaking patients at the primary and secondary practice settings and which, if any, foreign languages are spoken in the practice;
10. Whether the physician or podiatrist participates in the Virginia Medicaid Program and whether he is accepting new Medicaid patients;
11. A report on felony convictions including the date of the conviction, the nature of the conviction, the jurisdiction in which the conviction occurred, and the sentence imposed, if any;
12. Final orders of any regulatory board of another jurisdiction that result in the denial, probation, revocation, suspension, or restriction of any license or that results in the reprimand or censure of any license or the voluntary surrender of a license while under investigation in a state other than Virginia while under investigation, as well as any disciplinary action taken by a federal health institution or federal agency; and
13. Any final disciplinary or other action required to be reported to the board by health care institutions, other practitioners, insurance companies, health maintenance organizations, and professional organizations pursuant to §§54.1-2400.6, 54.1-2908, and 54.1-2909 that results in a suspension or revocation of privileges or the termination of employment.
B. Adjudicated notices and final orders or decision documents, subject to s 54.1-2400.2 F of the Code of Virginia, shall be made available on the profile. Information shall be posted indicating the availability of unadjudicated notices and of orders that have not yet become final.

C. For the sole purpose of expediting dissemination of information about a public health emergency, an email address or facsimile number shall be provided, if available. Such addresses or numbers shall not be published on the profile and shall not be released or made available for any other purpose.

18VAC85-20-285. Voluntary information.

A. The doctor may provide names of insurance plans accepted or managed care plans in which he participates.
B. The doctor may provide additional information on hours of continuing education earned, subspecialities obtained, honors or awards received.

18VAC85-20-290. Reporting of malpractice paid claims.

A. In compliance with requirements of §54.1-2910.1 of the Code of Virginia, a doctor of medicine, osteopathic medicine, or podiatry licensed by the board shall report all medical malpractice judgments and settlements of $10,000 or more in the most recent 10-year period within 30 days of the initial payment. A doctor shall report a medical malpractice judgment or settlement of less than $10,000 if any other medical malpractice judgment or settlement has been paid by or for the licensee within the preceding 12 months. Each report of a settlement or judgment shall indicate:

1. The year the judgment or settlement was paid.

2. The specialty in which the doctor was practicing at the time the incident occurred that resulted in the judgment or settlement.

3. The total amount of the judgment or settlement in United States dollars.

4. The city, state, and country in which the judgment or settlement occurred.

B. The board shall not release individually identifiable numeric values of reported judgments or settlements but shall use the information provided to determine the relative frequency of judgments or settlements described in terms of the number of doctors in each specialty and the percentage with malpractice judgments and settlements within the most recent 10-year period. The statistical methodology used will include any specialty with more than 10 judgments or settlements. For each specialty with more than 10 judgments or settlements, the top 16% of the judgments or settlements will be displayed as above average payments, the next 68% of the judgments or settlements will be displayed as average payments, and the last 16% of the judgments or settlements will be displayed as below average payments.

C. For purposes of reporting required under this section, medical malpractice judgment and medical malpractice settlement shall have the meanings ascribed in § 54.1-2900 of the Code of Virginia. A medical malpractice judgment or settlement shall include:

1. A lump sum payment or the first payment of multiple payments;

2. A payment made from personal funds;

3. A payment on behalf of a doctor of medicine, osteopathic medicine, or podiatry by a corporation or entity comprised solely of that doctor of medicine, osteopathic medicine, or podiatry; or

4. A payment on behalf of a doctor of medicine, osteopathic medicine or podiatry named in the claim where that doctor is dismissed as a condition of, or in consideration of the settlement, judgment or release. If a doctor is dismissed independently of the settlement, judgment or release, then the payment is not reportable.

18VAC85-20-300. Non-compliance or falsification of profile.

A. The failure to provide the information required by 18 VAC 85-20-280 and by 18 VAC 85-20-290 within 30 days of the request for information by the board or within 30 days of a change in the information on the profile may constitute unprofessional conduct and may subject the licensee to disciplinary action by the board.
B. Intentionally providing false information to the board for the practitioner profile system shall constitute unprofessional conduct and shall subject the licensee to disciplinary action by the board.

Revocation: The loss of licensure. A practitioner's license is revoked for a minimum of three years before he is eligible to petition for reinstatement (except in the case of a mandatory revocation. See § 54.1-2917 of the Code of Virginia). The practitioner cannot practice during the period of revocation.

Self-designated practice area: The practice area in which the licensee declares a special interest; i.e., family practice, pediatrics, urology, etc. Board Certification is not a requirement for selecting a self-designated practice area.

Self-reported: The licensee has reported this information and assumes responsibility for its accuracy and completeness. It has not been verified or confirmed by the Board of Medicine however the Board reserves the right to audit or investigate.

Settlement: In the context of a paid malpractice claim, a settlement is an agreement between the parties in which payment is made to the plaintiff to resolve the claim without proceeding to court. A court may approve the settlement, but it is not an award of the court. A settlement does not necessarily mean that the practitioner admits liability for damages sustained by the plaintiff.

Suspension: A practitioner's license is suspended for a specified period of time. A practitioner cannot practice until the suspension has been stayed, lifted or terminated by the Board.

Surrendered: By consent order, a practitioner agrees to surrender the license and the Board accepts the surrender in lieu of further proceedings. The practitioner can then no longer lawfully practice. "Surrendered" can also mean the surrender of the privilege to renew the license. This privilege is available to a practitioner whose license has expired for less than two years. Upon acceptance by the Board, the practitioner cannot renew the license without approval of the Board. Permanent surrender of the license or the privilege to renew means the practitioner agrees never to seek to regain the license and the ability to practice in Virginia.

Total US Dollar Amount: The value of the total amount of the paid claim in United States funds.

Virginia Notices and Orders: This section will either state that you have not been the subject of a Virginia Board of Medicine Notice or Order and ask you to confirm **or** if you do have Virginia notices and orders, a chronological listing will be available and the questionnaire will state that you have had the opportunity to review the notices and orders listed and it is complete and true. If you do have notices and orders and are completing the questionnaire online, you can select to view the scanned documents of any notices and orders on file at the Board of Medicine if you choose to. If completing a paper questionnaire, you can review attached copies of your notices and orders immediately following the questionnaire. You are asked to confirm that the information concerning notices and orders or lack of notices and orders pertaining to you is accurate, true, and complete. If you select "false" the Board will investigate and you will be contacted. Please note that selecting "true" does not signify that you agree with any notices and orders should you have them, it just signifies that the information provided is complete and you were presented with the opportunity to review any notices and orders that pertain to you that are on file at the Board of Medicine.

Glossary of Terms

A

Active License: Licensee may practice medicine, osteopathic medicine, or podiatry in Virginia.

Administrative Proceeding: Pursuant to the Virginia law, an informal conference or formal hearing in order to adjudicate a matter before the Board. (See §§ 2.2-4019 and 2.2-4020, and Chapter 29 of Title 54 of the Code of Virginia).

Admitting Privileges: The level of privilege that allows the licensee to admit patients under his or her care at that particular hospital.

Assistance: If you have questions or comments, contact us at info@vahealthprovider.com

B

Board Certified: Licensee has met the requirements for certification as defined by the American Board of Medical Specialties (AMBS), the Bureau of Osteopathic Specialists of the American Osteopathic Association (AOA), the American Board of Multiple Specialties in Podiatry (ABMSP), or the Council on Podiatric Medical Education of the American Podiatric Medical Association. Certification status can be checked on medical doctors and doctors of osteopathy through the ABMS website www.abms.org "Who's Certified" or verbal verification is available through the ABMS toll-free telephone service, 1-866-ASK-ABMS. The AOA lists doctors of osteopathy that have attained certification. If you wish to contact the AOA you can visit their website: www.osteopathic.org or call them at 800-621-1773. The Council on Podiatric Medical Education of the American Podiatric Medical Association recognizes board certification from the American Board of Podiatric Surgery and the American Board of Podiatric Orthopedics and Primary Podiatric Medicine. You can contact the American Board of Podiatric Orthopedics and Primary Podiatric Medicine at their website www.abpoppm.org or at 310-891-0100 to find out if a podiatrist is certified. Certification status can be checked on podiatrists through the American Board of Multiple Specialties in Podiatry online at www.abmsp.org or if you wish verbal confirmation, call 1-888-852-1422. The ABMSP offers this service free of charge.

C

Conclusions of Law: A determination by the Board about whether a practitioner violated the law and/or regulation.

Contact Us: If you have questions or comments, contact us at info@vahealthprovider.com

Continuing Education: The additional training the licensee pursues. TYPE I (accredited, sponsored activities) and TYPE II (self-study, teaching, non-approved courses, presentations, conferences). Beginning with 2002 renewals, 60 hours are required. Thirty of those hours must be TYPE I.

D

Data Collection in Progress: This message will appear under sections of recently required information. By regulation, doctors have thirty days to provide requested information.

Data Entry In Progress: This message will appear when a doctor has submitted his information to the Board via a paper questionnaire. Upon completion of data entry, a verification summary is then sent to the doctor to confirm his information was entered correctly. If the doctor does not notify the Board of any revisions within fourteen days, the information will automatically be available on the website.

E

Expired: Status of license when it is no longer valid for use.

F

Feedback: The Virginia Board of Medicine is interested in what you think of the website. Please e-mail your comments to us at info@vahealthprovider.com

Felony: A criminal offense punishable with death or confinement in a state correctional facility.

Fellowship: Medical study program with specific training usually within the doctor's chosen field of specialty.

Findings of Fact: The facts as determined by the Board pursuant to the evidence and testimony presented at the administrative proceeding or as agreed to in a consent order.

Formal Hearing: A "trial-like" proceeding at which the Board receives evidence and testimony regarding allegations of possible violations (See §§ 2.2-4020 and 54.1-2920 of the Code for Virginia). The practitioner may or may not appear at the hearing.

H

Help: For Help with the website - info@vahealthprovider.com

Hospital Affiliations: Any type of relationship a licensee has with a hospital either as an employee, independent contractor, or via type of privilege, not limited to but including Courtesy, Locum tenems, Admitting, Emeritus, Honorary, Temporary, etc. The definition of the various categories of privilege varies from hospital to hospital.

I

Inactive License: Licensee may not practice medicine, osteopathic medicine, or podiatry in Virginia. Licensee pays a reduced renewal fee; however, the licensee is exempt from complying with the Continuing Education requirements

Informal conference: A fact-finding meeting between an Informal Conference Committee of the

Board and a practitioner regarding allegations made by the Board. (See §§ 2.2-4019 and 54.1-2400 (10) of the Code of Virginia). The practitioner may or may not actually appear before the Committee.

Insurance Plans/Managed Care Plans: Doctors now have the option of listing up to ten insurance plans/managed care plans they accept or participate in. You may wish to check with your doctor and Insurance Plan/Managed Care Plan to ensure your doctor is a participating provider.

Internship: Former requirement for additional training after the completion of medical school. This additional training is now included as a post-graduate year of training (residency).

J

Judgment: In the context of a malpractice claim, a judgment is an award by a court, with or without a jury, to the plaintiff, in response to a lawsuit.

L

Law: Laws for the Physician Profile System are found in the *Code of Virginia* as follows:

§54.1-2910.1. Certain data required.

A. The Board of Medicine shall require all doctors of medicine, osteopathy and podiatry to report and shall make available the following information:

1. The names of the schools of medicine, osteopathy, or podiatry and the years of graduation;

2. Any graduate medical, osteopathic, or podiatric education at any institution approved by the Accreditation Council for Graduation Medical Education, the American Osteopathic Association or the Council on Podiatric Medical Education;

3. Any specialty board certification as approved by the American Board of Medical Specialties, the Bureau of Osteopathic Specialists of the American Osteopathic Association, the American Board of Multiple Specialties in Podiatry, or the Council on Podiatric Medical Education of the American Podiatric Medical Association;

4. The number of years in active, clinical practice as specified by regulations of the Board;

5. Any hospital affiliations;

6. Any appointments, within the most recent 10-year period, of the doctor to the faculty of a school of medicine, osteopathy or podiatry and any publications in peer-reviewed literature within the most recent five-year period and as specified by regulations of the Board;

7. The location and telephone number of any primary and secondary practice settings and the approximate percentage of the doctor's time spent practicing in each setting. For the sole purpose of expedited dissemination of information about a public health emergency, the doctor shall also provide to the Board any e-mail address or facsimile number; however, such e-mail address or

facsimile number shall not be published on the profile database and shall not be released or made available for any other purpose;

8. The access to any translating service provided to the primary and secondary practice settings of the doctor;

9. The status of the doctor's participation in the Virginia Medicaid Program;

10. Any final disciplinary or other action required to be reported to the Board by health care institutions, other practitioners, insurance companies, health maintenance organizations, and professional organizations pursuant to §§ 54.1-2400.6, 54.1-2908, and 54.1-2909 that results in a suspension or revocation of privileges or the termination of employment or a final order of the Board relating to disciplinary action;

11. Conviction of any felony; and

12. Other information related to the competency of doctors of medicine, osteopathy, and podiatry, as specified in the regulations of the Board.

B. In addition, the Board shall provide for voluntary reporting of insurance plans accepted and managed care plans in which the doctor participates.

C. The Board shall promulgate regulations to implement the provisions of this section, including, but not limited to, the release, upon request from a consumer, of such information relating to a specific doctor. The Board's regulations shall provide for reports to include all medical malpractice judgments and medical malpractice settlements of more than $10,000 within the most recent 10-year period in categories indicating the level of significance of each award or settlement; however, the specific numeric values of reported paid claims shall not be released in any individually identifiable manner under any circumstances. Notwithstanding this subsection, a licensee shall report a medical malpractice judgment or medical malpractice settlement of less than $10,000 if any other medical malpractice judgment or medical malpractice settlement has been paid by or for the licensee within the preceding 12 months.

D. This section shall not apply to any person licensed pursuant to §§ 54.1-2928.1, 54.1-2933.1, 54.1-2936, and 54.1-2937 or to any person holding an inactive license to practice medicine, osteopathy, or podiatry.

(1998, c. 744; 1999, c. 573; 2000, c. 199; 2001, c. 199; 2001, Sp. Sess. I, c. 5; 2002, c. 38; 2004, cc. 64, 703; 2007, c. 861; 2008, c. 479.)

Licensee: A person who meets the requirements to have a license in the State of Virginia

M

Medicare Participating Provider: A licensee who contractually accepts the participating provider fee schedule.

N

Notices or Statement of Particulars: A "Notice and/or "Statement of Particulars" contains a statement of charges that have not been proven. The Board will meet with the named practitioner to discuss these charges and make a decision, or settle the charges with a consent order. After the meeting, the Board may decide to exonerate the practitioner or dismiss the charges. Or, the Board may decide that some or all of the charges are proven and a violation of law or regulation occurred. If the evidence supports a violation, the Board may take appropriate action against the license of the practitioner. Until the Board issues a decision (by letter, order or consent order) that contains findings about these charges, they are not proven.

O

Optional Data Elements: Not required by law or regulations however, the physician has the option of including these elements in his profile. These elements include:
Continuing Education
Days of Week at Practice Locations
Email Address
Fax number at Practice Locations
Honors and Awards
Maiden name
Medicare participation
Website Address

Order: The document issued by the Board of Medicine indicating the Board's decision that the practitioner, as a matter of past or present fact, is or is not in violation of law or regulation. Typically, an order resolves the allegations in the Notice, and contains findings of fact and conclusions of law. It may impose a sanction or require some action by the practitioner. In some cases, the Board's decision is to dismiss the allegations in the Notice and such a decision is usually stated in a letter. "Order" also applies to "Consent Orders" which are agreed to by the practitioner, often without a meeting with the Board. Orders and letters containing the Board's resolution of allegations are public documents and copies are available.

P

Paid Claim: In the context of malpractice, a paid claim is a payment made to a person in response to a claim. It may be in the form of a "judgment" or "settlement."

Peer-Reviewed Literature: A journal or publication whose articles are reviewed and selected by an editorial board comprised of individuals having attained similar certification, education, training, and experience.

Practice Address: A location where the licensee engages in practice of medicine, osteopathic medicine, or podiatry regardless if patients are seen. Practitioners may designate a primary practice address and additional practice addresses.

Practitioner Has Not Provided Information: This message appears when a doctor has not yet completed his profile. By regulation, doctors have thirty days from the date of request from the Board to provide the requested information.

Probation: A status whereby a practitioner maintains his license but must comply with the terms and conditions required by the Board. The conditions may restrict the practice.

R

Regulation: Rules adopted by the Board to implement the Law. Regulations pertaining to the Physician Profile are:

18VAC85-20-280. Required information.

A. In compliance with requirements of §54.1-2910.1 of the Code of Virginia, a doctor of medicine, osteopathic medicine, or podiatry licensed by the board shall provide, upon initial request or whenever there is a change in the information that has been entered on the profile, the following information within 30 days:

1. The address and telephone number of the primary practice setting and all secondary practice settings with the percentage of time spent at each location;

2. Names of medical, osteopathic or podiatry schools and graduate medical or podiatric education programs attended with dates of graduation or completion of training;

3. Names and dates of specialty board certification, if any, as approved by the American Board of Medical Specialties, the Bureau of Osteopathic Specialists of the American Osteopathic Association or the Council on Podiatric Medical Education of the American Podiatric Medical Association;

4. Number of years in active, clinical practice in the United States or Canada following completion of medical or podiatric training and the number of years, if any, in active, clinical practice outside the United States or Canada;

5. The specialty, if any, in which the physician or podiatrist practices;

6. Names of hospitals with which the physician or podiatrist is affiliated;

7. Appointments within the past 10 years to medical or podiatry school faculties with the years of service and academic rank;

8. Publications, not to exceed 10 in number, in peer-reviewed literature within the most recent five-year period;

9. Whether there is access to translating services for non-English speaking patients at the primary and secondary practice settings and which, if any, foreign languages are spoken in the practice;

10. Whether the physician or podiatrist participates in the Virginia Medicaid Program and whether he is accepting new Medicaid patients;

11. A report on felony convictions including the date of the conviction, the nature of the conviction, the jurisdiction in which the conviction occurred, and the sentence imposed, if any;

12. Final orders of any regulatory board of another jurisdiction that result in the denial, probation, revocation, suspension, or restriction of any license or that results in the reprimand or censure of any license or the voluntary surrender of a license while under investigation in a state other than Virginia while under investigation, as well as any disciplinary action taken by a federal health institution or federal agency; and

13. Any final disciplinary or other action required to be reported to the board by health care institutions, other practitioners, insurance companies, health maintenance organizations, and professional organizations pursuant to §§54.1-2400.6, 54.1-2908, and 54.1-2909 that results in a suspension or revocation of privileges or the termination of employment.

B. Adjudicated notices and final orders or decision documents, subject to s 54.1-2400.2 F of the Code of Virginia, shall be made available on the profile. Information shall be posted indicating the availability of unadjudicated notices and of orders that have not yet become final.
C. For the sole purpose of expediting dissemination of information about a public health emergency, an email address or facsimile number shall be provided, if available. Such addresses or numbers shall not be published on the profile and shall not be released or made available for any other purpose.

18VAC85-20-285. Voluntary information.

A. The doctor may provide names of insurance plans accepted or managed care plans in which he participates.

B. The doctor may provide additional information on hours of continuing education earned, subspecialities obtained, honors or awards received.

18VAC85-20-290. Reporting of malpractice paid claims.

A. In compliance with requirements of §54.1-2910.1 of the Code of Virginia, a doctor of medicine, osteopathic medicine, or podiatry licensed by the board shall report all medical malpractice judgments and settlements of $10,000 or more in the most recent 10-year period within 30 days of the initial payment. A doctor shall report a medical malpractice judgment or settlement of less than $10,000 if any other medical malpractice judgment or settlement has been paid by or for the licensee within the preceding 12 months. Each report of a settlement or judgment shall indicate:

1. The year the judgment or settlement was paid.
2. The specialty in which the doctor was practicing at the time the incident occurred that resulted in the judgment or settlement.
3. The total amount of the judgment or settlement in United States dollars.
4. The city, state, and country in which the judgment or settlement occurred.

B. The board shall not release individually identifiable numeric values of reported judgments or settlements but shall use the information provided to determine the relative frequency of judgments or settlements described in terms of the number of doctors in each specialty and the percentage with malpractice judgments and settlements within the most recent 10-year period. The statistical methodology used will include any specialty with more than 10 judgments or settlements. For each specialty with more than 10 judgments or settlements, the top 16% of the judgments or settlements will be displayed as above average payments, the next 68% of the

judgments or settlements will be displayed as average payments, and the last 16% of the judgments or settlements will be displayed as below average payments.

C. For purposes of reporting required under this section, medical malpractice judgment and medical malpractice settlement shall have the meanings ascribed in § 54.1-2900 of the Code of Virginia. A medical malpractice judgment or settlement shall include:

1. A lump sum payment or the first payment of multiple payments;

2. A payment made from personal funds;

3. A payment on behalf of a doctor of medicine, osteopathic medicine, or podiatry by a corporation or entity comprised solely of that doctor of medicine, osteopathic medicine, or podiatry; or

4. A payment on behalf of a doctor of medicine, osteopathic medicine or podiatry named in the claim where that doctor is dismissed as a condition of, or in consideration of the settlement, judgment or release. If a doctor is dismissed independently of the settlement, judgment or release, then the payment is not reportable.

18VAC85-20-300. Non-compliance or falsification of profile.

A. The failure to provide the information required by 18 VAC 85-20-280 and by 18 VAC 85-20-290 within 30 days of the request for information by the board or within 30 days of a change in the information on the profile may constitute unprofessional conduct and may subject the licensee to disciplinary action by the board.

B. Intentionally providing false information to the board for the practitioner profile system shall constitute unprofessional conduct and shall subject the licensee to disciplinary action by the board.

Residency: Extended postgraduate training usually in relation to establishing a specialty field of medical practice.

Revocation: The loss of licensure. A practitioner's license is revoked for a minimum of one year before he is eligible to petition for reinstatement (except in the case of a mandatory revocation. See § 54.1-2917 of the Code of Virginia). The practitioner cannot practice during the period of revocation.

S

Self-designated practice area: The practice area in which the licensee declares a special interest; i.e., family practice, pediatrics, urology, etc. Board Certification is not a requirement for selecting a self-designated practice area.

Self-reported: The licensee has reported this information and assumes responsibility for its accuracy and completeness. It has not been verified or confirmed by the Board of Medicine; however the Board reserves the right to audit or investigate.

Settlement: In the context of a paid malpractice claim, a settlement is an agreement between the

parties in which payment is made to the plaintiff to resolve the claim without proceeding to court. A court may approve the settlement, but it is not an award of the court. A settlement does not necessarily mean that the practitioner admits liability for damages sustained by the plaintiff.

Surrendered: By consent order, a practitioner agrees to surrender the license and the Board accepts the surrender in lieu of further proceedings. The practitioner can then no longer lawfully practice. "Surrendered" can also mean the surrender of the privilege to renew the license. This privilege is available to a practitioner whose license has expired for less than two years. Upon acceptance by the Board, the practitioner cannot renew the license without approval of the Board. Permanent surrender of the license or the privilege to renew means the practitioner agrees never to seek to regain the license and the ability to practice in Virginia.

Suspension: A practitioner's license is suspended for a specified period of time. A practitioner cannot practice until the suspension has been stayed, lifted or terminated by the Board.

Office of the Attorney General

Mary Sue Terry
Attorney General

H. Lane Kneedler
Chief Deputy Attorney General

Deborah Love-Bryant
Chief-of-Staff

COMMONWEALTH of VIRGINIA
Office of the Attorney General

K. Marshall Cook
Deputy Attorney General
Finance & Transportation Division

R. Claire Guthrie
Deputy Attorney General
Human & Natural Resources Division

Gail Starling Marshall
Deputy Attorney General
Judicial Affairs Division

Stephen D. Rosenthal
Deputy Attorney General
Public Safety & Economic Development Div

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 Rocken 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 ...."

Virginia Board of Medicine on

Use of Confidential Consent Agreements

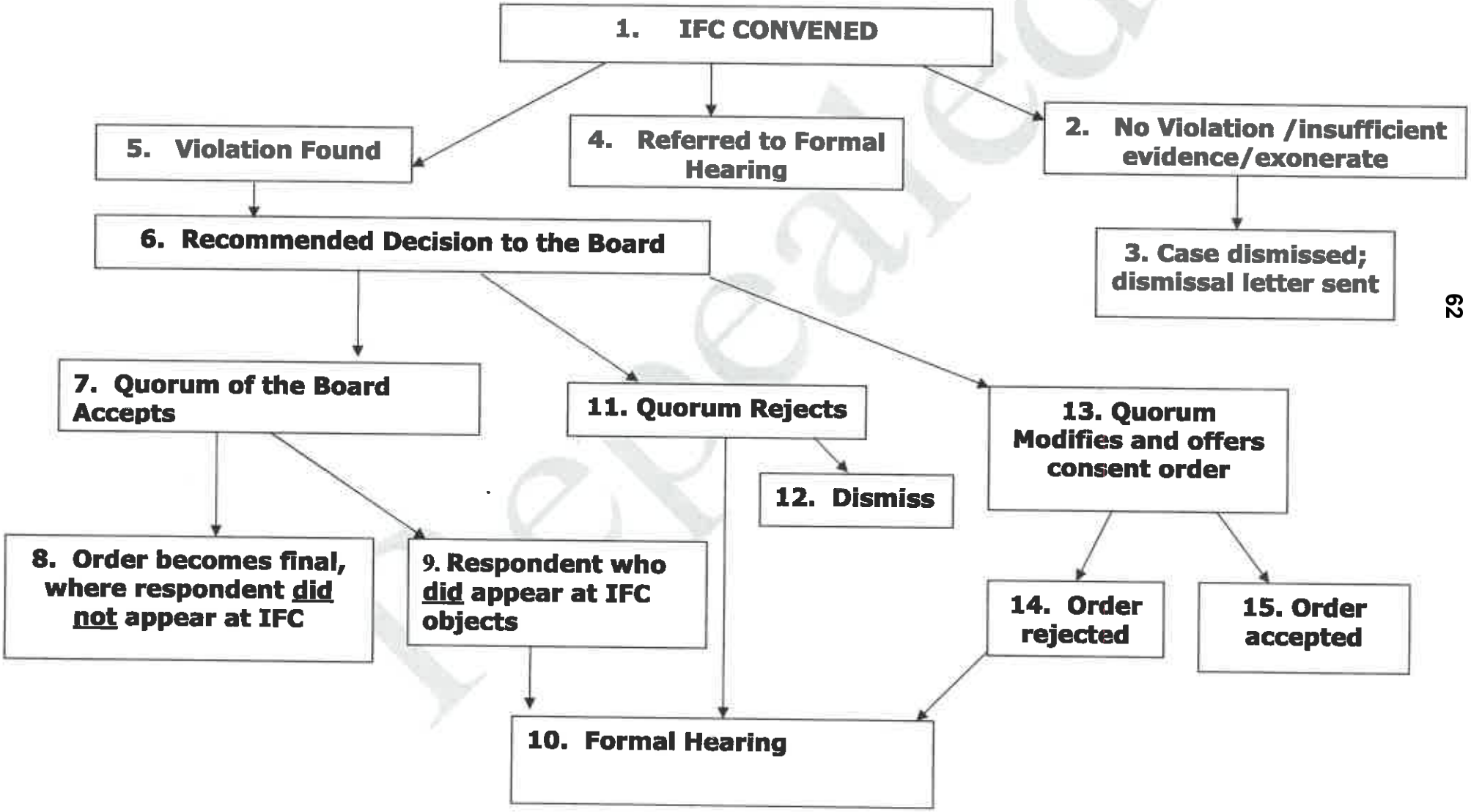
Pursuant to the provisions of Section 54.1-2400(14), the Board of Medicine may enter into a confidential consent agreement with a practitioner only in cases involving minor misconduct where there is little or no injury to a patient or the public and little likelihood of repetition by the practitioner. The board cannot enter into a confidential consent agreement if there is probable cause to believe the practitioner has (i) demonstrated gross negligence or intentional misconduct in the care of patients or (ii) conducted his practice in such a manner as to be a danger to the health and welfare of his patients or the public.

The determination as to the appropriateness of a confidential consent agreement shall be ~~delegated to the President, or another board member designated by the President, at the~~ made by the Board and/or Board staff at the probable cause stage through a review and recommendation by the Executive Director or Medical Review Coordinator. ~~For any case identified by the President for resolution by a confidential consent agreement, "appropriateness" includes determining any violation or terms, and authorizing entry on behalf of the Board.~~ The types of cases that may be subject to the use of a confidential consent agreement will include, but are not limited to, the following:

- Failure to complete required hours of continuing education
- Failure to complete the physician profile
- Advertising

Guidance Document: 85-25
Adopted: October 14, 2004

Guidance for Conduct of an Informal Conference by an Agency Subordinate of a Health Regulatory Board at the Department of Health Professions



Guidance Document: 85-25
Adopted: October 14, 2004

Narrative explanation of Flow Chart on Delegation to an Agency Subordinate

This describes the process in which a subordinate hears a case at an informal conference up to a case that may be referred to a formal hearing.

1. Pursuant to a notice, the designated agency subordinate ("subordinate") will convene the informal conference ("IFC"). An IFC before a subordinate is conducted in the same manner as an IFC before a committee of the board. Following the presentation of information by the parties, the subordinate will consider the evidence presented and render a recommended decision regarding the findings of fact, conclusions of law, and if appropriate, the sanction to be imposed.

2. The subordinate may recommend that the respondent be exonerated, that there be a finding of no violation, or that insufficient evidence exists to determine that a statutory and/or regulatory violation has occurred.

3. If the subordinate makes such a finding, the case is dismissed and a dismissal letter is issued to the respondent notifying him of the determination.

4. The subordinate may decide that the case should be referred to a formal hearing. A hearing before the board would then be scheduled and notice sent to the respondent.

5. The subordinate may determine that a violation has occurred and recommend the findings of fact and conclusions of law along with an appropriate sanction.

6. With the assistance of APD, the subordinate drafts a recommended decision, which includes the findings of fact, conclusions of law and sanction. The recommendation is provided to the respondent and to the board and must be ratified by a quorum of the board.

7. If a quorum of the board accepts the recommended decision and:

8. If the respondent <u>did not appear</u> at the IFC, the board's decision becomes a final order that can only be appealed to a circuit court; or

9-10. If the respondent <u>did appear</u> at the IFC and objects to the order, he may request a

formal hearing before the board. A case referred to a formal hearing proceeds in the same manner as cases considered by special conference committees convened pursuant to Va. Code § 54.1-2400(10). If the respondent who appeared at the IFC does not request a formal hearing, the order becomes final after a specified timeframe.

11. A quorum of the board may reject the recommended decision of the subordinate, in which case:

The board may decide to refer the case for a formal hearing **(10)**; or the board may decide to dismiss the case and a dismissal letter is issued to the respondent notifying him of the decision of the board **(12)**.

13. A quorum of the board may modify the subordinate's recommended decision, and a consent order reflecting the modified decision is presented to the respondent:

If the respondent accepts the consent order, it is duly entered **(15)**; or if the respondent rejects the consent order **(14)**, the case proceeds to a formal hearing before the board **(10)**.

Agenda Item: **Board Action –Periodic review of regulation**

Included in your agenda package:

- Copy of:

  Chapter 15: Regulations Governing Delegation to an Agency Subordinate

  Chapter 20: Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry and Chiropractic

- Copy of Periodic Review announcement

Action:

Recommend to the full Board retention of both chapters with no amendments to Chapter 15 and only edits and clarifications for Chapter 20

Virginia.gov Agencies | Governor

Logged in as
Elaine J. Yeatts

Agency **Department of Health Professions**

Board **Board of Medicine**

Chapter **Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic [18 VAC 85 – 20]**

Edit Review

Review 1647

Periodic Review of this Chapter

Includes a Small Business Impact Review

Date Filed: 4/30/2018

Review Announcement

Pursuant to Executive Order 17 (2014) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Board of Medicine is conducting a periodic review and small business impact review of 18VAC85-20-10 et seq., Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic.

The review of this regulation will be guided by the principles in Executive Order 17 (2014). http://dpb.virginia.gov/regs/EO17.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.

The comment period begins May 28, 2018, and ends on June 27, 2018.

Comments may be submitted online to the Virginia Regulatory Town Hall at http://www.townhall.virginia.gov/L/Forums.cfm. Comments may also be sent to Elaine Yeatts, Senior Policy Analyst, 9960 Mayland Drive, Henrico, VA 23233 Telephone: (804) 367-4688, FAX: (804) 527-4434; email address: Elaine.yeatts@dhp.virginia.gov

Comments must include the commenter's name and address (physical or email) information in order to receive a response to the comment from the agency. 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.

Public Comment Period

Begin Date: 5/28/2018 End Date: 6/27/2018

Comments Received: 0

Review Result

Pending

Attorney General Certification

Result of Review: Certified

Commonwealth of Virginia

REGULATIONS

GOVERNING DELEGATION TO AN AGENCY SUBORDINATE

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 85-15-10 et seq.

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

Revised Date: July 27, 2005

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

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

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18VAC85-15-10. Decision to delegate informal fact-finding proceedings to an agency subordinate.

In accordance with § 54.1-2400 (10) of the Code of Virginia, the board may delegate an informal fact-finding proceeding to an agency subordinate upon determination that probable cause exists that a practitioner may be subject to a disciplinary action.

18VAC85-15-20. Criteria for delegation.

Cases that may be delegated to an agency subordinate shall be limited to those involving:

1. The practitioner profile system;
2. Continuing competency;
3. Advertising;
4. Compliance with board orders;
5. Default on a federal or state-guaranteed educational loan or on a work-conditional scholarship or grant for the cost of a health professional education; or
6. Failure to provide medical records.

18VAC85-15-30. Criteria for an agency subordinate.

A. An agency subordinate may include board members, professional staff or other persons authorized and deemed by the board to be knowledgeable by virtue of their training and experience in administrative proceedings involving the regulation and discipline of health professionals to conduct an informal fact-finding proceeding.

B. The executive director shall maintain a list of appropriately qualified persons to whom an informal fact-finding proceeding may be delegated.

C. The board may delegate to the executive director the selection of the agency subordinate who is deemed appropriately qualified to conduct a proceeding based on the qualifications of the subordinate and the type of case being heard.

Commonwealth of Virginia

REGULATIONS

GOVERNING THE PRACTICE OF MEDICINE, OSTEOPATHY, PODIATRY AND CHIROPRACTIC

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 85-20-10 et seq.

Statutory Authority: § 54.1-2400 and Chapter 29 of Title 54.1 of the *Code of Virginia*

Revised Date: May 2, 2018

9960 Mayland Drive, Suite 300
Henrico, VA 23233-2463

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

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Part I. General Provisions.

18VAC85-20-10. Definitions.

A. The following words and terms when used in this chapter shall have the meanings ascribed to them in §54.1-2900 of the Code of Virginia:

Board

Healing arts

Practice of chiropractic

Practice of medicine or osteopathic medicine

Practice of podiatry

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

"Approved institution" means any accredited school or college of medicine, osteopathic medicine, podiatry, or chiropractic located in the United States, its territories, or Canada.

"Principal site" means the location in a foreign country where teaching and clinical facilities are located.

18VAC85-20-20. Public Participation Guidelines.

A separate board regulation, 18VAC85-11, entitled Public Participation Guidelines, provides for involvement of the public in the development of all regulations of the Virginia Board of Medicine.

18VAC85-20-21. Current addresses.

Each licensee shall furnish the board his current address of record. All notices required by law or by this chapter to be mailed by the board to any such licensee shall be validly given when mailed to the latest address of record given by the licensee. Any change in the address of record of the public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

18VAC85-20-22. Required fees.

A. Unless otherwise provided, fees established by the board shall not be refundable.

B. All examination fees shall be determined by and made payable as designated by the board.

C. The application fee for licensure in medicine, osteopathic medicine, and podiatry shall be $302, and the fee for licensure in chiropractic shall be $277.

D. The fee for a temporary authorization to practice medicine pursuant to § 54.1-2927 B (i) and (ii) of the Code of Virginia shall be $25.

E. The application fee for a limited professorial or fellow license issued pursuant to 18VAC85-20-210 shall be $55. The annual renewal fee shall be $35. For renewal of a limited professorial or fellow license in 2018, the fee shall be $30. An additional fee for late renewal of licensure shall be $15.

F. The application fee for a limited license to interns and residents pursuant to 18VAC85-20-220 shall be $55. The annual renewal fee shall be $35. For renewal of a limited license to interns and residents in 2018, the fee shall be $30. An additional fee for late renewal of licensure shall be $15.

G. The fee for a duplicate wall certificate shall be $15; the fee for a duplicate license shall be $5.

H. The fee for biennial renewal shall be $337 for licensure in medicine, osteopathic medicine, and podiatry and $312 for licensure in chiropractic, due in each even-numbered year in the licensee's birth month. An additional fee for processing a late renewal application within one renewal cycle shall be $115 for licensure in medicine, osteopathic medicine, and podiatry and $105 for licensure in chiropractic. For renewal of licensure in 2018, the fee shall be $270 for licensure in medicine, osteopathic medicine, and podiatry and $250 for licensure in chiropractic.

I. The fee for requesting reinstatement of licensure or certification pursuant to § 54.1-2408.2 of the Code of Virginia or for requesting reinstatement after any petition to reinstate the certificate or license of any person has been denied shall be $2,000.

J. The fee for reinstatement of a license issued by the Board of Medicine pursuant to § 54.1-2904 of the Code of Virginia that has expired for a period of two years or more shall be $497 for licensure in medicine, osteopathic medicine, and podiatry ($382 for reinstatement application in addition to the late fee of $115) and $472 for licensure in chiropractic ($367 for reinstatement application in addition to the late fee of $105). The fee shall be submitted with an application for licensure reinstatement.

K. The fee for a letter of verification of licensure shall be $10, and the fee for certification of grades to another jurisdiction by the board shall be $25. Fees shall be due and payable upon submitting a request for verification or certification to the board.

L. The fee for biennial renewal of an inactive license shall be $168, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $55 for each renewal cycle.

M. The fee for an application or for the biennial renewal of a restricted volunteer license shall be $75, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $25 for each renewal cycle. For renewal of a restricted volunteer license in 2018, the fee shall be $65.

N. The fee for a returned check shall be $35.

Part II. Standards of Professional Conduct.

18VAC85-20-25. Treating and prescribing for self or family.

A. Treating or prescribing shall be based on a bona fide practitioner-patient relationship, and prescribing shall meet the criteria set forth in § 54.1-3303 of the Code of Virginia.

B. A practitioner shall not prescribe a controlled substance to himself or a family member, other than Schedule VI as defined in § 54.1-3455 of the Code of Virginia, unless the prescribing occurs in an emergency situation or in isolated settings where there is no other qualified practitioner available to the patient, or it is for a single episode of an acute illness through one prescribed course of medication.

C. When treating or prescribing for self or family, the practitioner shall maintain a patient record documenting compliance with statutory criteria for a bona fide practitioner-patient relationship.

18VAC85-20-26. Patient records.

A. Practitioners shall comply with provisions of § 32.1-127.1:03 of the Code of Virginia related to the confidentiality and disclosure of patient records.

B. Practitioners shall provide patient records to another practitioner or to the patient or his personal representative in a timely manner in accordance with provisions of § 32.1-127.1:03 of the Code of Virginia.

C. Practitioners shall properly manage patient records and shall maintain timely, accurate, legible and complete patient records.

D. Practitioners shall maintain a patient record for a minimum of six years following the last patient encounter with the following exceptions:

1. Records of a minor child, including immunizations, shall be maintained until the child reaches the age of 18 or becomes emancipated, with a minimum time for record retention of six years from the last patient encounter regardless of the age of the child; or

2. Records that have previously been transferred to another practitioner or health care provider or provided to the patient or his personal representative; or

3. Records that are required by contractual obligation or federal law [may need] to be maintained for a longer period of time.

E. From October 19, 2005, practitioners shall post information or in some manner inform all patients concerning the time frame for record retention and destruction. Patient records shall only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.

F. When a practitioner is closing, selling or relocating his practice, he shall meet the requirements of § 54.1-2405 of the Code of Virginia for giving notice that copies of records can be sent to any like-regulated provider of the patient's choice or provided to the patient.

18VAC85-20-27. Confidentiality.

A. A practitioner shall not willfully or negligently breach the confidentiality between a practitioner and a patient. A breach of confidentiality that is required or permitted by applicable law or beyond the control of the practitioner shall not be considered negligent or willful.

B. Unauthorized use or disclosure of confidential information received from the Prescription Monitoring Program shall be grounds for disciplinary action.

18VAC85-20-28. Practitioner-patient communication; termination of relationship.

A. Communication with patients.

1. Except as provided in § 32.1-127.1:03 F of the Code of Virginia, a practitioner shall accurately inform a patient or his legally authorized representative of his medical diagnoses, prognosis and prescribed treatment or plan of care. A practitioner shall not deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a medication, treatment, or procedure prescribed or directed by the practitioner in the treatment of any disease or condition.

2. A practitioner shall present information relating to the patient's care to a patient or his legally authorized representative in understandable terms and encourage participation in the decisions regarding the patient's care.

3. Before surgery or any invasive procedure is performed, informed consent shall be obtained from the patient in accordance with the policies of the health care entity. Practitioners shall inform patients of the risks, benefits, and alternatives of the recommended surgery or invasive procedure that a reasonably prudent practitioner in similar practice in Virginia would tell a patient.

a. In the instance of a minor or a patient who is incapable of making an informed decision on his own behalf or is incapable of communicating such a decision due to a physical or mental disorder, the legally authorized person available to give consent shall be informed and the consent documented.

b. An exception to the requirement for consent prior to performance of surgery or an invasive procedure may be made in an emergency situation when a delay in obtaining consent would likely result in imminent harm to the patient.

c. For the purposes of this provision, "invasive procedure" shall mean any diagnostic or therapeutic procedure performed on a patient that is not part of routine, general care and for which the usual practice within the health care entity is to document specific informed consent from the patient or surrogate decision-maker prior to proceeding.

4. Practitioners shall adhere to requirements of § 32.1-162.18 of the Code of Virginia for obtaining informed consent from patients prior to involving them as subjects in human research, with the exception of retrospective chart reviews.

B. Termination of the practitioner/patient relationship.

1. The practitioner or the patient may terminate the relationship. In either case, the practitioner shall make a copy of the patient record available, except in situations where denial of access is allowed by law.

2. Except as provided in § 54.1-2962.2 of the Code of Virginia, a practitioner shall not terminate the relationship or make his services unavailable without documented notice to the patient that allows for a reasonable time to obtain the services of another practitioner.

18VAC85-20-29. Practitioner responsibility.

A. A practitioner shall not:
1. Knowingly allow subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice or area of responsibility. Practitioners shall delegate patient care only to subordinates who are properly trained and supervised;

2. Engage in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient;

3. Exploit the practitioner/patient relationship for personal gain.

B. Advocating for patient safety or improvement in patient care within a health care entity shall not constitute disruptive behavior provided the practitioner does not engage in behavior prohibited in A 2 of this section.

18VAC85-20-30. Advertising ethics.

A. Any statement specifying a fee, whether standard, discounted or free, for professional services which does not include the cost of all related procedures, services and products which, to a substantial likelihood, will be necessary for the completion of the advertised service as it would be understood by an ordinarily prudent person shall be deemed to be deceptive or misleading, or both. Where reasonable disclosure of all relevant variables and considerations is made, a statement of a range of prices for specifically described services shall not be deemed to be deceptive or misleading.

B. Advertising a discounted or free service, examination, or treatment and charging for any additional service, examination, or treatment which is performed as a result of and within 72 hours of the initial office visit in response to such advertisement is unprofessional conduct unless such professional services rendered are as a result of a bona fide emergency. This provision may not be waived by agreement of the patient and the practitioner.

C. Advertisements of discounts shall disclose the full fee that has been discounted. The practitioner shall maintain documented evidence to substantiate the discounted fees and shall make such information available to a consumer upon request.

D. A licensee shall disclose the complete name of the specialty board which conferred the certification when using or authorizing the use of the term "board certified" or any similar words or phrase calculated to convey the same meaning in any advertising for his practice.

E. A licensee of the board shall not advertise information which is false, misleading, or deceptive. For an advertisement for a single practitioner, it shall be presumed that the practitioner is

responsible and accountable for the validity and truthfulness of its content. For an advertisement for a practice in which there is more than one practitioner, the name of the practitioner or practitioners responsible and accountable for the content of the advertisement shall be documented and maintained by the practice for at least two years.

F. Documentation, scientific and otherwise, supporting claims made in an advertisement shall be maintained and available for the board's review for at least two years.

18VAC85-20-40. Vitamins, minerals and food supplements.

A. The recommendation or direction for the use of vitamins, minerals or food supplements and the rationale for that recommendation shall be documented by the practitioner. The recommendation or direction shall be based upon a reasonable expectation that such use will result in a favorable patient outcome, including preventive practices, and that a greater benefit will be achieved than that which can be expected without such use.

B. Vitamins, minerals, or food supplements, or a combination of the three, shall not be sold, dispensed, recommended, prescribed, or suggested in doses that would be contraindicated based on the individual patient's overall medical condition and medications.

C. The practitioner shall conform to the standards of his particular branch of the healing arts in the therapeutic application of vitamins, minerals or food supplement therapy.

18VAC85-20-50. Anabolic steroids.

A practitioner shall not sell, prescribe, or administer anabolic steroids to any patient for other than accepted therapeutic purposes.

18VAC85-20-60 to 18VAC85-20-70. [Repealed]

18VAC85-20-80. Solicitation or remuneration in exchange for referral.

A practitioner shall not knowingly and willfully solicit or receive any remuneration, directly or indirectly, in return for referring an individual to a facility or institution as defined in §37.2-100 of the Code of Virginia, or hospital as defined in §32.1-123 of the Code of Virginia.
Remuneration shall be defined as compensation, received in cash or in kind, but shall not include any payments, business arrangements, or payment practices allowed by Title 42, §1320a-7b(b) of the United States Code, as amended, or any regulations promulgated thereto.

18VAC85-20-90. Pharmacotherapy for weight loss.

A. A practitioner shall not prescribe amphetamine, Schedule II, for the purpose of weight reduction or control.

B. A practitioner shall not prescribe controlled substances, Schedules III through VI, for the purpose of weight reduction or control in the treatment of obesity, unless the following conditions are met:

1. An appropriate history and physical examination are performed and recorded at the time of initiation of pharmacotherapy for obesity by the prescribing physician, and the physician reviews the results of laboratory work, as indicated, including testing for thyroid function;

2. If the drug to be prescribed could adversely affect cardiac function, the physician shall review the results of an electrocardiogram performed and interpreted within 90 days of initial prescribing for treatment of obesity;

3. A diet and exercise program for weight loss is prescribed and recorded;

4. The patient is seen within the first 30 days following initiation of pharmacotherapy for weight loss, by the prescribing physician or a licensed practitioner with prescriptive authority working under the supervision of the prescribing physician, at which time a recording shall be made of blood pressure, pulse, and any other tests as may be necessary for monitoring potential adverse effects of drug therapy;

5. The treating physician shall direct the follow-up care, including the intervals for patient visits and the continuation of or any subsequent changes in pharmacotherapy. Continuation of prescribing for treatment of obesity shall occur only if the patient has continued progress toward achieving or maintaining a target weight and has no significant adverse effects from the prescribed program.

C. If specifically authorized in his practice agreement with a supervising or collaborating physician, a physician assistant or nurse practitioner may perform the physical examination, review tests, and prescribe Schedules III through VI controlled substances for treatment of obesity, as specified in subsection B of this section.

18VAC85-20-100. Sexual contact.

A. For purposes of § 54.1-2915 A 12 and A 19 of the Code of Virginia and this section, sexual contact includes, but is not limited to, sexual behavior or verbal or physical behavior which:

1. May reasonably be interpreted as intended for the sexual arousal or gratification of the practitioner, the patient, or both; or

2. May reasonably be interpreted as romantic involvement with a patient regardless of whether such involvement occurs in the professional setting or outside of it.

B. Sexual contact with a patient.

1. The determination of when a person is a patient for purposes of § 54.1-2915 A 19 of the Code of Virginia is made on a case-by-case basis with consideration given to the nature, extent, and context of the professional relationship between the practitioner and the person. The fact that a person is not actively receiving treatment or professional services from a practitioner is not determinative of this issue. A person is presumed to remain a patient until the patient-practitioner relationship is terminated.

2. The consent to, initiation of, or participation in sexual behavior or involvement with a practitioner by a patient does not change the nature of the conduct nor negate the statutory prohibition.

C. Sexual contact between a practitioner and a former patient.

Sexual contact between a practitioner and a former patient after termination of the practitioner-patient relationship may still constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge, or influence of emotions derived from the professional relationship.

D. Sexual contact between a practitioner and a key third party shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care. For purposes of this section, key third party of a patient shall mean: spouse or partner, parent or child, guardian, or legal representative of the patient.

E. Sexual contact between a medical supervisor and a medical trainee shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care.

18VAC85-20-105. Refusal to provide information.

A practitioner shall not willfully refuse to provide information or records as requested or required by the board or its representative pursuant to an investigation or to the enforcement of a statute or regulation.

Part III. Licensure: General and Educational Requirements.

18VAC85-20-110. [Repealed]

18VAC85-20-120. Prerequisites to licensure.

Every applicant for licensure shall:

1. Meet the educational requirements specified in 18VAC85-20-121 or 18VAC85-20-122 and the examination requirements as specified for each profession in 18VAC85-20-140;

2. File the complete application and appropriate fee as specified in 18VAC85-20-22 with the executive director of the board; and

3. File the required credentials with the executive director as specified below:

a. Graduates of an approved institution shall file:

(1) Documentary evidence that he received a degree from the institution; and

(2) A complete chronological record of all professional activities since graduation from professional school, giving location, dates, and types of services performed.

b. Graduates of an institution not approved by an accrediting agency recognized by the board shall file:

(1) Documentary evidence of education as required by 18VAC85-20-122;

(2) A translation made and endorsed by a consul or by a professional translating service of all such documents not in the English language; and

(3) A complete chronological record of all professional activities since graduation from professional school, giving location, dates, and types of services performed.

18VAC85-20-121. Educational requirements: Graduates of approved institutions.

A. Such an applicant shall be a graduate of an institution that meets the criteria appropriate to the profession in which he seeks to be licensed, which are as follows:

1. For licensure in medicine. The institution shall be approved or accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association, or by the Committee for the Accreditation of Canadian Medical Schools or its appropriate subsidiary agencies or any other organization approved by the board.

2. For licensure in osteopathic medicine. The institution shall be approved or accredited by the Bureau of Professional Education of the American Osteopathic Association or any other organization approved by the board.

3. For licensure in podiatry. The institution shall be approved and recommended by the Council on Podiatric Medical Education of the American Podiatry Podiatric Medical Association or any other organization approved by the board.

B. Such an applicant for licensure in medicine, osteopathic medicine, or podiatry shall provide evidence of having completed 12 months of satisfactory postgraduate training as an intern or resident in one program or institution when such a program or institution is approved by an accrediting agency recognized by the board for internship and residency training.

C. For licensure in chiropractic.

1. If the applicant matriculated in a chiropractic college on or after July 1, 1975, he shall be a graduate of a chiropractic college accredited by the Commission on Accreditation of the Council of Chiropractic Education or any other organization approved by the board.

2. If the applicant matriculated in a chiropractic college prior to July 1, 1975, he shall be a graduate of a chiropractic college accredited by the American Chiropractic Association or the International Chiropractic Association or any other organization approved by the board.

18VAC85-20-122. Educational requirements: graduates and former students of institutions not approved by an accrediting agency recognized by the board.

A. A graduate of an institution not approved by an accrediting agency recognized by the board shall present documentary evidence that he:

1. Was enrolled and physically in attendance at the institution's principal site for a minimum of two consecutive years and fulfilled at least half of the degree requirements while enrolled two consecutive academic years at the institution's principal site.

2. Has fulfilled the applicable requirements of § 54.1-2930 of the Code of Virginia.

3. Has obtained a certificate from the Educational Council of Foreign Medical Graduates (ECFMG), or its equivalent. Proof of licensure by the board of another state or territory of the United States or a province of Canada may be accepted in lieu of ECFMG certification.

4. Has had supervised clinical training as a part of his curriculum in an approved hospital, institution or school of medicine offering an approved residency program in the specialty area for the clinical training received or in a program acceptable to the board and deemed a substantially equivalent experience, if such training was received in the United States.

5. Has completed one year of satisfactory postgraduate training as an intern, resident, or clinical fellow. The one year shall include at least 12 months in one program or institution approved by an accrediting agency recognized by the board for internship or residency training or in a clinical fellowship acceptable to the board in the same or a related field. The board may substitute continuous full-time practice of five years or more with a limited professorial license in Virginia and one year of postgraduate training in a foreign country in lieu of one year of postgraduate training.

6. Has received a degree from the institution.

B. A former student who has completed all degree requirements except social services and postgraduate internship at a school not approved by an accrediting agency recognized by the board shall be considered for licensure provided that he:

1. Has fulfilled the requirements of subdivisions A 1 through 5 of this section;

2. Has qualified for and completed an appropriate supervised clinical training program as established by the American Medical Association; and

3. Presents a document issued by the school certifying that he has met all the formal requirements of the institution for a degree except social services and postgraduate internship.

18VAC85-20-130. [Repealed]

18VAC85-20-131. Requirements to practice acupuncture.

A. To be qualified to practice acupuncture, licensed doctors of medicine, osteopathic medicine, podiatry, and chiropractic shall first have obtained at least 200 hours of instruction in general and basic aspects of the practice of acupuncture, specific uses and techniques of acupuncture, and

indications and contraindications for acupuncture administration. At least 50 hours of the 200 hours of instruction shall be clinical experience supervised by a person legally authorized to practice acupuncture in any jurisdiction of the United States. Persons who held a license as a physician acupuncturist prior to July 1, 2000, shall not be required to obtain the 50 hours of clinical experience.

B. The use of acupuncture as a treatment modality shall be appropriate to the doctor's scope of practice as defined in §54.1-2900 of the Code of Virginia.

Part IV. Licensure: Examination Requirements.

18VAC85-20-140. Examinations, general.

A. The Executive Director of the Board of Medicine or his designee shall review each application for licensure and in no case shall an applicant be licensed unless there is evidence that the applicant has passed an examination equivalent to the Virginia Board of Medicine examination required at the time he was examined and meets all requirements of Part III (18VAC85-20-120 et seq.) of this chapter. If the executive director or his designee is not fully satisfied that the applicant meets all applicable requirements of Part III of this chapter and this part, he shall refer the application to the Credentials Committee for a determination on licensure.

B. A Doctor of Medicine or Osteopathic Medicine who has passed the examination of the National Board of Medical Examiners or of the National Board of Osteopathic Medical Examiners, Federation Licensing Examination, or the United States Medical Licensing Examination, or the examination of the Licensing Medical Council of Canada or other such examinations as prescribed in §54.1-2913.1 of the Code of Virginia may be accepted for licensure.

C. A Doctor of Podiatry who has passed the National Board of Podiatric Medical Examiners examination and has passed a clinical competence examination acceptable to the board may be accepted for licensure.

D. A Doctor of Chiropractic who has met the requirements of one of the following may be accepted for licensure:

1. An applicant who graduated after January 31, 1996, shall document successful completion of Parts I, II, III, and IV of the National Board of Chiropractic Examiners examination (NBCE).

2. An applicant who graduated from January 31, 1991, to January 31, 1996, shall document successful completion of Parts I, II, and III of the National Board of Chiropractic Examiners examination (NBCE).

3. An applicant who graduated from July 1, 1965, to January 31, 1991, shall document successful completion of Parts I, II, and III of the NBCE, or Parts I and II of the NBCE and the Special Purpose Examination for Chiropractic (SPEC), and document evidence of licensure in another state for at least two years immediately preceding his application.

4. An applicant who graduated prior to July 1, 1965, shall document successful completion of the SPEC, and document evidence of licensure in another state for at least two years immediately preceding his application.

E. The following provisions shall apply for applicants taking Step 3 of the United States Medical Licensing Examination or the Podiatric Medical Licensing Examination:

1. Applicants for licensure in medicine and osteopathic medicine may be eligible to sit for Step 3 of the United States Medical Licensing Examination (USMLE) upon evidence of having passed Steps 1 and 2 of the United States Medical Licensing Examination (USMLE).

2. Applicants who sat for the United States Medical Licensing Examination (USMLE) shall provide evidence of passing Steps 1, 2, and 3 within a 10-year period unless the applicant is board certified in a specialty approved by the American Board of Medical Specialties or the Bureau of Osteopathic Specialists of the American Osteopathic Association.

3. Applicants shall have completed the required training or be engaged in their final year of required postgraduate training.

4. Applicants for licensure in podiatry shall provide evidence of having passed the National Board of Podiatric Medical Examiners Examination to be eligible to sit for the Podiatric Medical Licensing Examination (PMLEXIS) in Virginia.

18VAC85-20-150 to 18VAC85-20-200. [Repealed]

Part V. Limited or Temporary Licenses.

18VAC85-20-210. Limited licenses to foreign medical graduates.

A. A physician who graduated from an institution not approved by an accrediting agency recognized by the board applying for a limited professorial license or a limited fellow license to practice medicine in an approved medical school or college in Virginia shall:

1. Submit evidence of authorization to practice medicine in a foreign country.

2. Submit evidence of a standard Educational Commission for Foreign Medical Graduates (ECFMG) certificate or its equivalent. Such required evidence may be waived by the Credentials Committee or its designee based on other evidence of medical competency and English proficiency.

3. Submit a recommendation from the dean of an accredited medical school in Virginia that the applicant is a person of professorial or of fellow rank whose knowledge and special training meet the requirements of §54.1-2936 of the Code of Virginia.

B. The limited professorial license or limited fellow license applies only to the practice of medicine in hospitals and outpatient clinics where medical students, interns or residents rotate and patient care is provided by the medical school or college recommending the applicant.

1. The limited professorial license shall be valid for one year and may be renewed annually upon recommendation of the dean of the medical school and upon continued full-time service as a faculty member.

2. The limited fellow license shall be valid for one year and may be renewed not more than twice upon the recommendation of the dean of the medical school and upon continued full-time employment as a fellow.

C. An individual who has practiced with a limited professorial license for five continuous years may have a waiver when applying for a full license to practice medicine in the Commonwealth of Virginia. The limited professorial licensee applying for a full license shall meet the requirements of 18VAC85-20-120 and 18VAC85-20-122.

18VAC85-20-220. Temporary licenses to interns and residents.

A. An intern or resident applying for a temporary license to practice in Virginia shall:

1. Successfully complete the preliminary academic education required for admission to examinations given by the board in his particular field of practice, and submit a letter of confirmation from the registrar of the school or college conferring the professional degree, or official transcripts confirming the professional degree and date the degree was received.

2. Submit a recommendation from the applicant's chief or director of graduate medical education of the approved internship or residency program specifying acceptance. The beginning and ending dates of the internship or residency shall be specified.

3. Submit evidence of a standard Educational Commission for Foreign Medical Graduates (ECFMG) certificate or its equivalent if the candidate graduated from a school not approved by an accrediting agency recognized by the board.

B. The intern or resident license applies only to the practice in the hospital or outpatient clinics where the internship or residency is served. Outpatient clinics in a hospital or other facility must be a recognized part of an internship or residency program.

C. The intern or resident license shall be renewed annually upon the recommendation of the chief or director of graduate medical education of the internship or residency program.

A residency program transfer request shall be submitted to the board in lieu of a full application.

D. The extent and scope of the duties and professional services rendered by the intern or resident shall be confined to persons who are bona fide patients within the hospital or who receive treatment and advice in an outpatient department of the hospital or outpatient clinic where the internship or residency is served.

E. The intern and resident shall be responsible and accountable at all times to a fully licensed member of the staff where the internship or residency is served. The intern and resident is prohibited from employment outside of the graduate medical educational program where a full license is required.

F. The intern or resident shall abide by the respective accrediting requirements of the internship or residency as approved by the Liaison Council on Graduate Education of the American Medical Association, American Osteopathic Association, American Podiatric Medical Association, or Council on Chiropractic Education.

18VAC85-20-225. Registration for voluntary practice by out-of-state licenses.

Any doctor of medicine, osteopathic medicine, podiatry or chiropractic who does not hold a license to practice in Virginia and who seeks registration to practice under subdivision 27 of §54.1-2901 of the Code of Virginia on a voluntary basis under the auspices of a publicly supported, all volunteer, nonprofit organization that sponsors the provision of health care to populations of underserved people shall:

1. File a complete application for registration on a form provided by the board at least five business days prior to engaging in such practice. An incomplete application will not be considered;

2. Provide a complete record of professional licensure in each state in which he has held a license and a copy of any current license;

3. Provide the name of the nonprofit organization, the dates and location of the voluntary provision of services;

4. Pay a registration fee of $10; and

5. Provide a notarized statement from a representative of the nonprofit organization attesting to its compliance with provisions of subdivision 27 of §54.1-2901 of the Code of Virginia.

18VAC85-20-226. Restricted volunteer license.

A. Any doctor of medicine, osteopathic medicine, podiatry or chiropractic who held an unrestricted license issued by the Virginia Board of Medicine or by a board in another state as a licensee in good standing at the time the license expired or became inactive may be issued a restricted volunteer license to practice without compensation in a clinic that is organized in whole or in part for the delivery of health care services without charge in accordance with §54.1-106 of the Code of Virginia.

B. To be issued a restricted volunteer license, a doctor of medicine, osteopathic medicine, podiatry or chiropractic shall submit an application to the board that documents compliance with requirements of §54.1-2928.1 of the Code of Virginia and the application fee prescribed in 18VAC85-20-22.

C. The licensee who intends to continue practicing with a restricted volunteer license shall renew biennially during his birth month, meet the continued competency requirements prescribed in subsection D of this section, and pay to the board the renewal fee prescribed in 18VAC85-20-22.

D. The holder of a restricted volunteer license shall not be required to attest to hours of continuing education for the first renewal of such a license. For each renewal thereafter, the licensee shall attest to 30 hours obtained during the two years immediately preceding renewal with at least 15

hours of Type 1 activities or courses offered by an accredited sponsor or organization sanctioned by the profession and no more than 15 hours of Type 2 activities or courses.

Part VI. Renewal of License; Reinstatement.

18VAC85-20-230. Renewal of an active license.

A. Every licensee who intends to maintain an active license shall renew his license biennially during his birth month, meet the continued competency requirements prescribed in 18VAC85-20-235, and pay to the board the renewal fee prescribed in 18VAC85-20-22.

B. An additional fee to cover administrative costs for processing a late application shall be imposed by the board as prescribed in subsection H of 18VAC85-20-22.

18VAC85-20-235. Continued competency requirements for renewal of an active license.

A. In order to renew an active license biennially, a practitioner shall attest to completion of at least 60 hours of continuing learning activities within the two years immediately preceding renewal as follows:

1. A minimum of 30 of the 60 hours shall be in Type 1 activities or courses offered by an accredited sponsor or organization sanctioned by the profession.

a. Type 1 hours in chiropractic shall be clinical hours that are approved by a college or university accredited by the Council on Chiropractic Education or any other organization approved by the board.

b. Type 1 hours in podiatry shall be accredited by the American Podiatric Medical Association, the American Council of Certified Podiatric Physicians and Surgeons or any other organization approved by the board.

2. No more than 30 of the 60 hours may be Type 2 activities or courses, which may or may not be approved by an accredited sponsor or organization but which shall be chosen by the licensee to address such areas as ethics, standards of care, patient safety, new medical technology, and patient communication. Up to 15 of the Type 2 continuing education hours may be satisfied through delivery of services, without compensation, to low-income individuals receiving services through a local health department or a free clinic organized in whole or primarily for the delivery of health services. One hour of continuing education may be credited for one hour of providing such volunteer services. For the purpose of continuing education credit for voluntary service, documentation by the health department or free clinic shall be acceptable.

B. A practitioner shall be exempt from the continuing competency requirements for the first biennial renewal following the date of initial licensure in Virginia.

C. The practitioner shall retain in his records all supporting documentation for a period of six years following the renewal of an active license.

D. The board shall periodically conduct a random audit of its active licensees to determine compliance. The practitioners selected for the audit shall provide all supporting documentation within 30 days of receiving notification of the audit.

E. Failure to comply with these requirements may subject the licensee to disciplinary action by the board.

F. The board may grant an extension of the deadline for continuing competency requirements for up to one year for good cause shown upon a written request from the licensee prior to the renewal date.

G. The board may grant an exemption for all or part of the requirements for circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

H. The board may grant an exemption for all or part of the requirements for a licensee who :

1. Is practicing solely in an uncompensated position, provided his practice is under the direction of a physician fully licensed by the board; or

2. Is practicing solely as a medical examiner, provided the licensee obtains six hours of medical examiner training per year provided by the Office of the Chief Medical Examiner.

18VAC85-20-236. Inactive license.

A doctor of medicine, osteopathic medicine, podiatry or chiropractic who holds a current, unrestricted license in Virginia may, upon a request on the renewal application and submission of the required fee, be issued an inactive license. The holder of an inactive license shall not be required to maintain continuing competency requirements and shall not be entitled to perform any act requiring a license to practice medicine, osteopathic medicine, podiatry or chiropractic in Virginia.

18VAC85-20-240. Reinstatement of an inactive or lapsed license.

A. A practitioner whose license has been lapsed for two successive years or more and who requests reinstatement of licensure shall:

1. File a completed application for reinstatement;

2. Pay the reinstatement fee prescribed in 18VAC85-20-22; and

3. Provide documentation of having completed continued competency hours equal to the requirement for the number of years, not to exceed four years, in which the license has been lapsed.

B. An inactive licensee may reactivate his license upon submission of the required application, payment of the difference between the current renewal fee for inactive licensure and the current renewal fee for active licensure, and documentation of having completed continued competency hours equal to the requirement for the number of years, not to exceed four years, in which the license has been inactive.

C. If a practitioner has not engaged in active practice in his profession for more than four years and wishes to reinstate or reactivate his license, the board may require the practitioner to pass one of the following examinations. For the purpose of determining active practice, the practitioner shall provide evidence of at least 640 hours of clinical practice within the four years immediately preceding his application for reinstatement or reactivation.

1. The Special Purpose Examination (SPEX) given by the Federation of State Medical Boards.

2. The Comprehensive Osteopathic Medical Variable Purpose Examination—USA (COMVEX-USA) given by the National Board of Osteopathic Examiners.

3. The Special Purposes Examination for Chiropractic (SPEC) given by the National Board of Chiropractic Examiners.

4. A special purpose examination or other evidence of continuing competency to practice podiatric medicine as acceptable to the board.

D. The board reserves the right to deny a request for reinstatement or reactivation to any licensee who has been determined to have committed an act in violation of §54.1-2915 of the Code of Virginia or any provisions of this chapter.

18VAC85-20-250 to 18VAC85-20-270. [Repealed]

Part VII. Practitioner Profile System.

18VAC85-20-280. Required information.

A. In compliance with requirements of §54.1-2910.1 of the Code of Virginia, a doctor of medicine, osteopathic medicine, or podiatry licensed by the board shall provide, upon initial request or whenever there is a change in the information that has been entered on the profile, the following information within 30 days:

1. The address and telephone number of the primary practice setting and all secondary practice settings with the percentage of time spent at each location;

2. Names of medical, osteopathic or podiatry schools and graduate medical or podiatric education programs attended with dates of graduation or completion of training;

3. Names and dates of specialty board certification, if any, as approved by the American Board of Medical Specialties, the Bureau of Osteopathic Specialists of the American Osteopathic Association or the Council on Podiatric Medical Education of the American Podiatric Medical Association;

4. Number of years in active, clinical practice in the United States or Canada following completion of medical or podiatric training and the number of years, if any, in active, clinical practice outside the United States or Canada;

5. The specialty, if any, in which the physician or podiatrist practices;

6. Names of hospitals with which the physician or podiatrist is affiliated;

7. Appointments within the past 10 years to medical or podiatry school faculties with the years of service and academic rank;

8. Publications, not to exceed 10 in number, in peer-reviewed literature within the most recent five-year period;

9. Whether there is access to translating services for non-English speaking patients at the primary and secondary practice settings and which, if any, foreign languages are spoken in the practice;

10. Whether the physician or podiatrist participates in the Virginia Medicaid Program and whether he is accepting new Medicaid patients;

11. A report on felony convictions including the date of the conviction, the nature of the conviction, the jurisdiction in which the conviction occurred, and the sentence imposed, if any; and

12. Final orders of any regulatory board of another jurisdiction that result in the denial, probation, revocation, suspension, or restriction of any license or that results in the reprimand or censure of any license or the voluntary surrender of a license while under investigation in a state other than Virginia while under investigation, as well as any disciplinary action taken by a federal health institution or federal agency.

13. Any final disciplinary or other action required to be reported to the board by health care institutions, other practitioners, insurance companies, health maintenance organizations, and professional organizations pursuant to §§ 54.1-2400.6, 54.1-2908, and 54.1-2909 that results in a suspension or revocation of privileges or the termination of employment.

B. Adjudicated notices and final orders or decision documents, subject to §54.1-2400.2 F of the Code of Virginia, shall be made available on the profile. Information shall be posted indicating the availability of unadjudicated notices and of orders that have not yet become final.

C. For the sole purpose of expediting dissemination of information about a public health emergency, an email address or facsimile number shall be provided, if available. Such addresses or numbers shall not be published on the profile and shall not be released or made available for any other purpose.

18VAC85-20-285. Voluntary information.

A. The doctor may provide names of insurance plans accepted or managed care plans in which he participates.

B. The doctor may provide additional information on hours of continuing education earned, subspecialties obtained, and honors or awards received.

18VAC85-20-290. Reporting of medical malpractice judgments and settlements.

A. In compliance with requirements of § 54.1-2910.1 of the Code of Virginia, a doctor of medicine, osteopathic medicine, or podiatry licensed by the board shall report all medical malpractice judgments and settlements of more than $10,000 in the most recent 10-year period within 30 days of the initial payment. A doctor shall report a medical malpractice judgment or settlement of less than $10,000 if any other medical malpractice judgment or settlement has been paid by or for the licensee within the preceeding 12 months. Each report of a settlement or judgment shall indicate:

1. The year the judgment or settlement was paid.

2. The specialty in which the doctor was practicing at the time the incident occurred that resulted in the judgment or settlement.

3. The total amount of the judgment or settlement in United States dollars.

4. The city, state, and country in which the judgment or settlement occurred.

B. The board shall not release individually identifiable numeric values of reported judgments or settlements but shall use the information provided to determine the relative frequency of judgments or settlements described in terms of the number of doctors in each specialty and the percentage with malpractice judgments and settlements within the most recent 10-year period. The statistical methodology used will include any specialty with more than 10 judgments or settlements. For each specialty with more than 10 judgments or settlements, the top 16% of the judgments or settlements will be displayed as above average payments, the next 68% of the judgments or settlements will be displayed as average payments, and the last 16% of the judgments or settlements will be displayed as below average payments.

C. For purposes of reporting required under this section, medical malpractice judgment and medical malpractice settlement shall have the meanings ascribed in § 54.1-2900 of the Code of Virginia. A medical malpractice judgment or settlement shall include:

1. A lump sum payment or the first payment of multiple payments;

2. A payment made from personal funds;

3. A payment on behalf of a doctor of medicine, osteopathic medicine, or podiatry by a corporation or entity comprised solely of that doctor of medicine, osteopathic medicine, or podiatry; or

4. A payment on behalf of a doctor of medicine, osteopathic medicine or podiatry named in the claim where that doctor is dismissed as a condition of, or in consideration of the settlement, judgment or release. If a doctor is dismissed independently of the settlement, judgment or release, then the payment is not reportable.

18VAC85-20-300. Noncompliance or falsification of profile.

A. The failure to provide the information required by 18VAC85-20-280 and 18VAC85-20-290 within 30 days of the request for information by the board or within 30 days of a change in the information on the profile may constitute unprofessional conduct and may subject the licensee to disciplinary action by the board.

B. Intentionally providing false information to the board for the physician profile system shall constitute unprofessional conduct and shall subject the licensee to disciplinary action by the board.

Part VIII. Office-Based Anesthesia.

18VAC85-20-310. Definitions.

"Advanced resuscitative techniques" means methods learned in certification courses for Advanced Cardiopulmonary Life Support (ACLS), or Pediatric Advanced Life Support (PALS).

"Deep sedation" means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients often require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

"General anesthesia" means a drug-induced loss of consciousness during which patients are not arousable even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive-pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

"Local anesthesia" means a transient and reversible loss of sensation in a circumscribed portion of the body produced by a local anesthetic agent.

"Minimal sedation/anxiolysis" means a drug-induced state during which a patient responds normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are usually not affected.

"Moderate sedation/conscious sedation" means a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are usually required to maintain a patent airway, and spontaneous ventilation is usually adequate. Cardiovascular function is usually maintained.

"Monitoring" means the continual clinical observation of patients and the use of instruments to measure and display the values of certain physiologic variables such as pulse, oxygen saturation, level of consciousness, blood pressure and respiration.

"Office-based" means any setting other than (i) a licensed hospital as defined in §32.1-123 of the Code of Virginia or state-operated hospitals or (ii) a facility directly maintained or operated by the federal government.

"Physical status classification" means a description used in determining the physical status of a patient as specified by the American Society of Anesthesiologists. Classifications are Class 1 for a normal healthy patient; Class 2 for a patient with mild systemic disease; Class 3 for a patient with severe systemic disease limiting activity but not incapacitation; Class 4 for a patient with incapacitating systemic disease that is a constant threat to life; and Class 5 for a moribund patient not expected to live 24 hours with or without surgery.

"Regional anesthesia" means the administration of anesthetic agents to a patient to interrupt nerve impulses without the loss of consciousness and includes minor and major conductive blocks.

"Minor conductive block" means the injection of local anesthesia to stop or prevent a painful sensation in a circumscribed area of the body (local infiltration or local nerve block), or the block of a nerve by refrigeration. Minor conductive nerve blocks include, but are not limited to, peribulbar blocks, pudenal blocks and ankle blocks.

"Major conductive block" means the use of local anesthesia to stop or prevent the transmission of painful sensations from large nerves, groups of nerves, nerve roots or the spinal cord. Major nerve blocks include, but are not limited to epidural, spinal, caudal, femoral, interscalene and brachial plexus.

"Topical anesthesia" means an anesthetic agent applied directly to the skin or mucous membranes, intended to produce a transient and reversible loss of sensation to a circumscribed area.

18VAC85-20-320. General provisions.

A. Applicability of requirements for office-based anesthesia.

1. The administration of topical anesthesia, local anesthesia, minor conductive blocks, or minimal sedation/anxiolysis, not involving a drug-induced alteration of consciousness other than minimal preoperative tranquilization, is not subject to the requirements for office-based anesthesia in this part. A health care practitioner administering such agents shall adhere to an accepted standard of care as appropriate to the level of anesthesia or sedation, including evaluation, drug selection, administration, and management of complications.

2. The administration of moderate sedation/conscious sedation, deep sedation, general anesthesia, or regional anesthesia consisting of a major conductive block is subject to these requirements for office-based anesthesia in this part. The administration of 300 milligrams or more of lidocaine or equivalent doses of local anesthetics shall be deemed to be subject to these requirements for office-based anesthesia in this part.

3. Levels of anesthesia or sedation referred to in this chapter shall relate to the level of anesthesia or sedation intended and documented by the practitioner in the preoperative anesthesia plan.

B. A doctor of medicine, osteopathic medicine, or podiatry administering office-based anesthesia or supervising such administration shall:

1. Perform a preanesthetic evaluation and examination or ensure that it has been performed;

2. Develop the anesthesia plan or ensure that it has been developed;

3. Ensure that the anesthesia plan has been discussed with the patient or responsible party preoperatively and informed consent has been obtained;

4. Ensure patient assessment and monitoring through the preprocedure, periprocedure, and post-procedure phases, addressing not only physical and functional status, but also physiological and cognitive status;

5. Ensure provision of indicated post-anesthesia care;

6. Remain physically present or immediately available, as appropriate, to manage complications and emergencies until discharge criteria have been met; and

7. Document any complications occurring during surgery or during recovery in the medical record.

C. All written policies, procedures, and protocols required for office-based anesthesia shall be maintained and available for inspection at the facility.

18VAC85-20-330. Qualifications of providers.

A. Doctors who utilize office-based anesthesia shall ensure that all medical personnel assisting in providing patient care are appropriately trained, qualified and supervised, are sufficient in numbers to provide adequate care, and maintain training in basic cardiopulmonary resuscitation.

B. All providers of office-based anesthesia shall hold the appropriate license and have the necessary training and skills to deliver the level of anesthesia being provided.

1. Deep sedation, general anesthesia or a major conductive block shall be administered by an anesthesiologist or by a certified registered nurse anesthetist. If a major conductive block is performed for diagnostic or therapeutic purposes, it may be administered by a doctor qualified by training and scope of practice.

2. Moderate sedation/conscious sedation may be administered by the operating doctor with the assistance of and monitoring by a licensed nurse, a physician assistant or a licensed intern or resident.

C. Additional training.

1. On or after December 18, 2003, the doctor who provides office-based anesthesia or who supervises the administration of anesthesia shall maintain current certification in advanced resuscitation techniques.

2. Any doctor who administers office-based anesthesia without the use of an anesthesiologist or certified registered nurse anesthetist shall obtain four hours of continuing education in topics related to anesthesia within the 60 hours required each biennium for licensure renewal, which are subject to random audit by the board.

18VAC85-20-340. Procedure/anesthesia selection and patient evaluation.

A. A written protocol shall be developed and followed for procedure selection to include but not be limited to:

1. The doctor providing or supervising the anesthesia shall ensure that the procedure to be undertaken is within the scope of practice of the health care practitioners and the capabilities of the facility.

2. The procedure or combined procedures shall be of a duration and degree of complexity that shall not exceed four hours and that will permit the patient to recover and be discharged from the facility in less than 24 hours. The procedure or combined procedures may be extended for up to eight hours if the anesthesia is provided by an anesthesiologist or a certified registered nurse anesthetist.

3. The level of anesthesia used shall be appropriate for the patient, the surgical procedure, the clinical setting, the education and training of the personnel, and the equipment available. The choice of specific anesthesia agents and techniques shall focus on providing an anesthetic that will be effective and appropriate and will address the specific needs of patients while also ensuring rapid recovery to normal function with maximum efforts to control post-operative pain, nausea, or other side effects.

B. A written protocol shall be developed for patient evaluation to include but not be limited to:

1. The preoperative anesthesia evaluation of a patient shall be performed by the health care practitioner administering the anesthesia or supervising the administration of anesthesia. It shall consist of performing an appropriate history and physical examination, determining the patient's physical status classification, developing a plan of anesthesia care, acquainting the patient or the responsible individual with the proposed plan, and discussing the risks and benefits.

2. The condition of the patient, specific morbidities that complicate anesthetic management, the specific intrinsic risks involved, and the nature of the planned procedure shall be considered in evaluating a patient for office-based anesthesia.

3. Patients who have pre-existing medical or other conditions that may be of particular risk for complications shall be referred to a facility appropriate for the procedure and administration of anesthesia. Nothing relieves the licensed health care practitioner of the responsibility to make a medical determination of the appropriate surgical facility or setting.

C. Office-based anesthesia shall only be provided for patients in physical status classifications for Classes I, II and III. Patients in Classes IV and V shall not be provided anesthesia in an office-based setting.

18VAC85-20-350. Informed consent.

A. Prior to administration, the anesthesia plan shall be discussed with the patient or responsible party by the health care practitioner administering the anesthesia or supervising the administration of anesthesia. Informed consent for the nature and objectives of the anesthesia planned shall be in writing and obtained from the patient or responsible party before the procedure is performed. Such consent shall include a discussion of discharge planning and what care or assistance the patient is expected to require after discharge. Informed consent shall only be obtained after a discussion of the risks, benefits, and alternatives, contain the name of the anesthesia provider, and be documented in the medical record.

B. The surgical consent forms shall be executed by the patient or the responsible party and shall contain a statement that the doctor performing the surgery is board certified or board eligible by one of the American Board of Medical Specialties boards, the Bureau of Osteopathic Specialists of the American Osteopathic Association, or the American Board of Foot and Ankle Surgery. The forms shall either list which board or contain a statement that doctor performing the surgery is not board certified or board eligible.

C. The surgical consent forms shall indicate whether the surgery is elective or medically necessary. If a consent is obtained in an emergency, the surgical consent form shall indicate the nature of the emergency.

18VAC85-20-360. Monitoring.

A. A written protocol shall be developed for monitoring equipment to include but not be limited to:

1. Monitoring equipment shall be appropriate for the type of anesthesia and the nature of the facility. At a minimum, provisions shall be made for a reliable source of oxygen, suction, resuscitation equipment and emergency drugs.

2. In locations where anesthesia is administered, there shall be adequate anesthesia apparatus and equipment to ensure appropriate monitoring of patients. All equipment shall be maintained, tested and inspected according to manufacturer's specifications, and backup power shall be sufficient to ensure patient protection in the event of an emergency.

3. When anesthesia services are provided to infants and children, the required equipment, medication and resuscitative capabilities shall be appropriately sized and calibrated for children.

B. To administer office-based moderate sedation/conscious sedation, the following equipment, supplies and pharmacological agents are required:

1. Appropriate equipment to manage airways;

2. Drugs and equipment to treat shock and anaphylactic reactions;

3. Precordial stethoscope;

4. Pulse oximeter with appropriate alarms or an equivalent method of measuring oxygen saturation;

5. Continuous electrocardiograph;

6. Devices for measuring blood pressure, heart rate and respiratory rate;

7. Defibrillator; and

8. Accepted method of identifying and preventing the interchangeability of gases.

C. In addition to requirements in subsection B of this section, to administer general anesthesia, deep sedation or major conductive blocks, the following equipment, supplies and pharmacological agents are required:

1. Drugs to treat malignant hyperthermia, when triggering agents are used;

2. Peripheral nerve stimulator, if a muscle relaxant is used; and

3. If using an anesthesia machine, the following shall be included:

a. End-tidal carbon dioxide monitor (capnograph);

b. In-circuit oxygen analyzer designed to monitor oxygen concentration within breathing circuit by displaying oxygen percent of the total respiratory mixture;

c. Oxygen failure-protection devices (fail-safe system) that have the capacity to announce a reduction in oxygen pressure and, at lower levels of oxygen pressure, to discontinue other gases when the pressure of the supply of oxygen is reduced;

d. Vaporizer exclusion (interlock) system, which ensures that only one vaporizer, and therefore only a single anesthetic agent can be actualized on any anesthesia machine at one time;

e. Pressure-compensated anesthesia vaporizers, designed to administer a constant non-pulsatile output, which shall not be placed in the circuit downstream of the oxygen flush valve;

f. Flow meters and controllers, which can accurately gauge concentration of oxygen relative to the anesthetic agent being administered and prevent oxygen mixtures of less than 21% from being administered;

g. Alarm systems for high (disconnect), low (subatmospheric) and minimum ventilatory pressures in the breathing circuit for each patient under general anesthesia; and

h. A gas evacuation system.

D. A written protocol shall be developed for monitoring procedures to include but not be limited to:

1. Physiologic monitoring of patients shall be appropriate for the type of anesthesia and individual patient needs, including continuous monitoring and assessment of ventilation, oxygenation, cardiovascular status, body temperature, neuromuscular function and status, and patient positioning.

2. Intraoperative patient evaluation shall include continuous clinical observation and continuous anesthesia monitoring.

3. A health care practitioner administering general anesthesia or deep sedation shall remain present and available in the facility to monitor a patient until the patient meets the discharge criteria. A health care practitioner administering moderate sedation/conscious sedation shall routinely monitor a patient according to procedures consistent with such administration.

18VAC85-20-370. Emergency and transfer protocols.

A. There shall be written protocols for handling emergency situations, including medical emergencies and internal and external disasters. All personnel shall be appropriately trained in and regularly review the protocols and the equipment and procedures for handling emergencies.

B. There shall be written protocols for the timely and safe transfer of patients to a prespecified hospital or hospitals within a reasonable proximity. For purposes of this section, "reasonable proximity" shall mean that a licensed general hospital capable of providing necessary services is normally accessible within 30 minutes of the office. There shall be a written or electronic transfer agreement with such hospital or hospitals.

18VAC85-20-380. Discharge policies and procedures.

A. There shall be written policies and procedures outlining discharge criteria. Such criteria shall include stable vital signs, responsiveness and orientation, ability to move voluntarily, controlled pain, and minimal nausea and vomiting.

B. Discharge from anesthesia care is the responsibility of the health care practitioner providing or the doctor supervising the anesthesia care and shall only occur when:

1. The patient has met specific physician-defined criteria; and

2. The health care practitioner providing or the doctor supervising the anesthetic care has given the order for discharge.

C. Written instructions and an emergency phone number shall be provided to the patient. Patients shall be discharged with a responsible individual who has been instructed with regard to the patient's care.

D. At least one person trained in advanced resuscitative techniques shall be immediately available until all patients are discharged.

18VAC85-20-390. Reporting requirements.

The doctor administering the anesthesia or supervising such administration shall report to the board within 30 days any incident relating to the administration of anesthesia that results in patient death, either intraoperatively or within the immediate 72-hour postoperative period or in transport of a patient to a hospital for a stay of more than 24 hours.

Part IX. Mixing, Diluting or Reconstituting of Drugs for Administration.

18VAC85-20-400. Requirements for immediate-use sterile mixing, diluting or reconstituting.

A. For the purposes of this chapter, the mixing, diluting, or reconstituting of sterile manufactured drug products when there is no direct contact contamination and administration begins within 10 hours of the completion time of preparation shall be considered immediate-use with the exception of drugs in fat emulsion for which immediate use shall be one hour. If manufacturers' instructions

or any other accepted standard specifies or indicates an appropriate time between preparation and administration of less than 10 hours, the mixing, diluting or reconstituting shall be in accordance with the lesser time. No direct contact contamination means that there is no contamination from touch, gloves, bare skin or secretions from the mouth or nose. Emergency drugs used in the practice of anesthesiology and administration of allergens may exceed 10 hours after completion of the preparation, provided administration does not exceed the specified expiration date of a multiple use vial and there is compliance with all other requirements of this section.

B. Doctors of medicine or osteopathic medicine who engage in immediate-use mixing, diluting or reconstituting shall:

1. Utilize the practices and principles of disinfection techniques, aseptic manipulations and solution compatibility in immediate-use mixing, diluting or reconstituting;

2. Ensure that all personnel under their supervision who are involved in immediate-use mixing, diluting or reconstituting are appropriately and properly trained in and utilize the practices and principles of disinfection techniques, aseptic manipulations and solution compatibility;

3. Establish and implement procedures for verification of the accuracy of the product that has been mixed, diluted, or reconstituted to include a second check performed by a doctor of medicine or osteopathic medicine, or by a physician assistant or a registered nurse who has been specifically trained pursuant to subdivision 2 of this subsection in immediate-use mixing, diluting, or reconstituting. Mixing, diluting, or reconstituting that is performed by a doctor of medicine or osteopathic medicine, or by a specifically trained physician assistant or registered nurse or mixing, diluting, or reconstituting of vaccines does not require a second check;

4. Provide a designated, sanitary work space and equipment appropriate for aseptic manipulations;

5. Document or ensure that personnel under his supervision document in the patient record or other readily retrievable record that identifies the patient; the names of drugs mixed, diluted or reconstituted; and the date of administration; and

6. Develop and maintain written policies and procedures to be followed in mixing, diluting or reconstituting of sterile products and for the training of personnel.

C. Any mixing, diluting or reconstituting of drug products that are hazardous to personnel shall be performed consistent with requirements of all applicable federal and state laws and regulations for safety and air quality, to include but not be limited to those of the Occupational Safety and Health Administration (OSHA). For the purposes of this chapter, Appendix A of the National Institute for Occupational Safety and Health publication (NIOSH Publication No. 2004-165), Preventing Occupational Exposure to Antineoplastic and Other Hazardous Drugs in Health Care Settings is incorporated by reference for the list of hazardous drug products and can be found at www.cdc.gov/niosh/docs/2004-165.

18VAC85-20-410. Requirements for low-, medium- or high-risk sterile mixing, diluting or reconstituting.

A. Any mixing, diluting or reconstituting of sterile products that does not meet the criteria for immediate-use as set forth in 18VAC85-20-400 A shall be defined as low-, medium-, or high-risk compounding under the definitions of Chapter 797 of the U.S. Pharmacopeia (USP).

B. Until July 1, 2007, all low-, medium-, or high-risk mixing, diluting or reconstituting of sterile products shall comply with the standards for immediate-use mixing, diluting or reconstituting as specified in 18VAC85-20-400. Beginning July 1, 2007, doctors of medicine or osteopathic medicine who engage in low-, medium-, or high-risk mixing, diluting or reconstituting of sterile products shall comply with all applicable requirements of the USP Chapter 797. Subsequent changes to the USP Chapter 797 shall apply within one year of the official announcement by USP.

C. A current copy, in any published format, of USP Chapter 797 shall be maintained at the location where low-, medium- or high-risk mixing, diluting or reconstituting of sterile products is performed.

18VAC85-20-420. Responsibilities of doctors who mix, dilute or reconstitute drugs in their practices.

A. Doctors of medicine or osteopathic medicine who delegate the mixing, diluting or reconstituting of sterile drug products for administration retain responsibility for patient care and shall monitor and document any adverse responses to the drugs.

B. Doctors who engage in the mixing, diluting or reconstituting of sterile drug products in their practices shall disclose this information to the board in a manner prescribed by the board and are subject to unannounced inspections by the board or its agents.

The travel regulations require that "travelers must submit the Travel Expense Reimbursement Voucher with 30 days after completion of their trip". (CAPP Topic 20335, State Travel Regulations, p.7)

In order for the agency to be in compliance with the state travel regulations, please submit your request for today's meeting no later than

October 9, 2018

Virginia Board of Medicine
2019 Board Meeting Dates

Full Board Meetings

February 14-16, 2019	DHP/Richmond, VA	Board Rooms TBA
June 13-15, 2019	DHP/Richmond, VA	Board Rooms TBA
October 17-19, 2019	DHP/Richmond, VA	Board Rooms TBA

Times for the above meetings are 8:30 a.m. to 5:00 p.m.

Executive Committee Meetings

April 5, 2019	DHP/Richmond, VA	Board Rooms TBA
August 2, 2019	DHP/Richmond, VA	Board Rooms TBA
December 6, 2019	DHP/Richmond, VA	Board Rooms TBA

Times for the above meetings are 8:30 a.m. to 5:00 p.m.

Legislative Committee Meetings

January 11, 2019	DHP/Richmond, VA	Board Rooms TBA
May 17, 2019	DHP/Richmond, VA	Board Rooms TBA
September 6, 2019	DHP/Richmond, VA	Board Rooms TBA

Times for the above meetings are 8:30 a.m. to 1:00 p.m.

Credentials Committee Meetings

January 9, 2019	February 20, 2019	March 13, 2019
April 17, 2019	May 29, 2019	June 26, 2019
July 24, 2019	August 21, 2019	September 25, 2019
October 23, 2019	November 13, 2019	December (TBA), 2019

Times for the Credentials Committee meetings - TBA

Advisory Board on:

Behavioral Analysts			10:00 a.m.
January 21	May 20	September 30	
Genetic Counseling			1:00 p.m.
January 21	May 20	September 30	
Occupational Therapy			10:00 a.m.
January 22	May 21	October 1	
Respiratory Care			1:00 p.m.
January 22	May 21	October 1	
Acupuncture			10:00 a.m.
January 23	May 22	October 2	
Radiological Technology			1:00 p.m.
January 23	May 22	October 2	
Athletic Training			10:00 a.m.
January 24	May 23	October 3	
Physician Assistants			1:00 p.m.
January 24	May 23	October 3	
Midwifery			10:00 a.m.
January 25	May 24	October 4	
Polysomnographic Technology			1:00 p.m.
January 25	May 24	October 4	

Joint Boards of Medicine and Nursing

TBA