Sunset Review: Evaluation of the State Board of Physicians and Allied Health Advisory Committees

DEPARTMENT OF LEGISLATIVE SERVICES DECEMBER 2019

Sunset Review: Evaluation of the State Board of Physicians and Allied Health Advisory Committees

Department of Legislative Services
Office of Policy Analysis
Annapolis, Maryland

December 2019

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DEPARTMENT OF LEGISLATIVE SERVICES
OFFICE OF POLICY ANALYSIS
MARYLAND GENERAL ASSEMBLY

Victoria L. Gruber
Executive Director

Ryan Bishop
Director

December 31, 2019

The Honorable Thomas V. Mike Miller, Jr., President of the Senate
The Honorable Adrienne A. Jones, Speaker of the House of Delegates
Members of the General Assembly

Ladies and Gentlemen:

The Department of Legislative Services (DLS) has completed its evaluation of the State Board of Physicians (MBP) as required by the Maryland Program Evaluation Act. This evaluation process is more commonly known as "sunset review" because the entities subject to evaluation are usually subject to termination; typically, legislative action must be taken to reauthorize them. Although scheduled for evaluation in 2021, Chapter 419 of 2019 advanced the termination dates of MBP and the related allied health advisory committees (with the exception of the Physician Assistants Advisory Committee) to June 1, 2020, and required an evaluation by DLS during the 2019 interim. This report was prepared to assist the committees designated to review MBP – the Senate Education, Health, and Environmental Affairs Committee and the House Health and Government Operations Committee – in making their recommendations to the full General Assembly. The board is scheduled to terminate on June 1, 2020.

As part of this evaluation, DLS reviewed board-related statutes, regulations, and annual reports; attended disciplinary panel and advisory committee meetings; conducted an online survey of MBP licensees; and conducted interviews with interested parties, including board and allied health advisory committee members, key board staff, board counsel, and representatives of professional associations representing occupations licensed by MBP.

DLS finds that MBP's statutory authority could be clarified or enhanced, particularly related to the ability to take disciplinary action. Likewise, board licensure, renewal, and reinstatement processes could be refined. Additionally, MBP's responsiveness to licensees could be improved. Accordingly, recommendations made by DLS generally provide clarity to existing statute, increase uniformity in processes among the health occupations regulated by MBP, enhance board effectiveness, and remove outdated requirements and references.

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Based on these findings, DLS makes a total of 28 recommendations. We would like to acknowledge the cooperation and assistance provided by MBP members and staff, the allied health advisory committees, and the Maryland Department of Health (MDH) throughout the review process. MBP and MDH were provided a draft copy of the report for factual review and comment prior to its publication; written comments from the board are enclosed as Appendix 6 to this report.

Sincerely,

Victoria L. Gruber
Executive Director

Ryan Bishop
Director

VLG:RB/JBC/km

Enclosure

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Executive Summary

Pursuant to the Maryland Program Evaluation Act, the Department of Legislative Services (DLS) has evaluated the State Board of Physicians (MBP), which is scheduled to terminate June 1, 2020. DLS finds that the board generally fulfills its stated mission to protect the public by effectively regulating physicians and allied health professionals. Further, board members and staff are dedicated and highly cognizant of MBP's mission. The board has made significant progress and addressed most of the issues identified in the 2016 sunset evaluation.

The board has made improvements in their licensing process, particularly as it relates to renewals. However, in a survey conducted by DLS, licensees noted the fairly short window for online renewal prior to the license expiration. A longer renewal window would be helpful for those licensees who are already aware of their license expiration date and prefer to plan ahead.

Recommendation 1: The board should allow a licensee to complete an online license renewal at any time during the 90 days immediately preceding license expiration.

Board staff has expressed concern that malpractice lawsuits are not always reported to the board, thereby making this profile category unreliable for the public. A description of "none reported" on a practitioner's profile may not accurately reflect whether a licensee has had an adverse judgment.

Recommendation 2: Statute should be amended to require a licensee profile to specify that malpractice information is "as reported to the board by the licensee."

Since the prior sunset evaluation, the board has had more experience with the implementation of criminal history records check (CHRC). One problem is the confusion caused by licenses submitting the initial CHRC but in some cases failing to complete the CHRC, if needed (*i.e.,* the fingerprints are illegible or a previously unreported name change yields incomplete results).

Recommendation 3: Statute should be amended to require an applicant for licensure or license renewal to *complete*, rather than *submit to*, a criminal history records check. Statute should be similarly amended to allow the board to discipline a licensee for failure to *complete* a criminal history records check.

There are currently two ways in which a physician licensed outside of the State can obtain a Maryland license. Chapter 470 of 2018 entered Maryland into the Interstate Compact on Medical Licensure, providing a streamlined process that allows physicians to become licensed in multiple states and enhancing the portability of a medical license. The Act took effect July 1, 2019, and terminates September 30, 2022. Prior to the Interstate Compact on Medical Licensure, out-of-state physicians could only obtain a license through reciprocity, as authorized by Chapters 460 and 461 of 2016.

Recommendation 4: To better understand the efficacy and efficiency of licensing physicians from out-of-state, in its 2021 annual report, the board should (1) include an update on licensing by reciprocity and through the Interstate Medical Licensure Compact; and (2) make recommendations on whether to continue either or both methods of licensure and whether any statutory changes are needed to accomplish the goal of streamlining licensure for out-of-state physicians.

Athletic trainers are authorized to assume duties under an evaluation and treatment protocol after receiving a written recommendation for approval from the Athletic Trainer Advisory Committee (ATAC). Waiting for this approval can cause delays in athletic trainers performing their job duties. The evaluation and treatment protocol is similar to delegation agreements required for physician assistants (PA); however, a PA may practice on the date the board receives the delegation agreement, and the agreement does not need to be approved by the Physician Assistant Advisory Committee.

Recommendation 5: To streamline the licensing process for athletic trainers, statute should be amended to authorize an athletic trainer to begin practice on the date that the applicant receives acknowledgement that board staff has received the completed application for an athletic trainer license and accompanying evaluation and treatment protocol appropriate to the scope of practice without first receiving approval from ATAC if the protocol is given preliminary approval by board staff and (1) does not include specialized tasks or (2) includes specialized tasks that have been previously approved by the board.

PA delegation agreements are made between PAs and a supervising physician. However, it is unclear if PAs can terminate the delegation agreement or when the board must be notified of a change in the PA's employment circumstances.

Recommendation 6: Statute should be amended to clarify that a physician assistant may begin practice on the date that the applicant receives acknowledgement that board staff has received the completed delegation agreement. Statute should also be amended to require a physician assistant and supervising physician to notify the board if the physician assistant has been terminated *for any reason*. Finally, statute should be amended to allow a physician assistant to terminate a delegation agreement with a supervising physician.

Statute is unclear as to when the board is authorized to terminate or void an athletic trainer's evaluation and treatment protocol or a PA's delegation agreement when there is a change in licensure status for the allied health practitioner or their supervising physician. Changes in licensure status could include the expiration and nonrenewal of either of the licenses, the death of a licensee, discipline of a licensee by suspension or revocation, or the surrender of a license.

Recommendation 7: Statute should be amended to authorize the board to terminate an evaluation and treatment protocol or a delegation agreement when either a supervising physician or an allied health practitioner has a change in licensure status such that they are unable

to legally practice and, in the case of a change in licensure status for a supervising physician, there is no acceptable alternate physician available.

In the survey of licensees conducted by DLS, many of the allied health practitioners expressed concerns regarding the redundancy of State licensure requirements and the requirements of their respective national organizations. Further, several allied health State licenses require certification by a national organization that is approved by the board.

Recommendation 8: The board should consult with the appropriate allied health advisory committees and review licensure requirements for allied health professionals to determine if requirements for national certification create opportunities to simplify the State licensing process or reduce State licensing fees for these allied health professionals.

Exceptions for physician licensure exist under certain limited circumstances outlined in §§ 14-302 and 14-302.1 of the Health Occupations Article. While not written for this purpose, an existing exception for physicians in neighboring states could be interpreted to allow for the practice of telemedicine without a Maryland license.

Recommendation 9: Statute should be amended to clarify and narrowly tailor the exception to licensure for physicians in neighboring states to apply only to a physician ordering home health care services who has performed an in-person evaluation and to remove the requirement for reciprocal provisions in neighboring states.

Statute allows a physician who is licensed and resides in another jurisdiction to practice medicine in a hospital without a license while engaged in clinical training with a licensed physician but first requires the hospital to receive approval from the board. This approval process may delay the treatment and is an unnecessary layer of oversight.

Recommendation 10: Statute should be amended to authorize a hospital to bring in a physician who is licensed and resides in another jurisdiction to practice medicine without a Maryland license while engaged in clinical training with a licensed physician in Maryland without the need for application to the board. For clarity, statute should be further amended to combine and reorganize the two statutory sections governing exceptions to physician licensure.

As part of their duties, a respiratory care practitioner may be called on to travel with a patient who is being transported to ensure the patient's stable breathing during transport. In some instances, this could include transport of a patient into the State from another jurisdiction. Though the practitioner is licensed in the state in which the patient begins their journey, on crossing the Maryland borders the practitioner begins practicing without a license.

Recommendation 11: Statute should be amended to create an exception to licensure to allow a respiratory care practitioner licensed outside the State to practice respiratory care on a patient who is being transported into Maryland.

One of the most common allegations investigated by MBP is a violation of the standard of quality medical care, which

requires a peer review. After the peer review is completed, the physician has 10 business days to respond to the peer review findings, which licensees expressed is a very short window.

Recommendation 12: Statute should be amended to allow the board to amend its regulations to increase the amount of time a respondent has to address findings in a peer review from 10 business days to 20 business days for cases of failure to meet appropriate standards of care as determined by peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State.

The number of peer reviews required for standard of care complaints has frequently been a discussion item for MBP and stakeholders. One assertion made by MBP in various reports is that the two peer reviewers required by statute often agree, making the requirement unnecessary and increasing costs.

Recommendation 13: Beginning with the fiscal 2020 annual report, the board should include the number of standard of care cases brought before the board; how many of these cases were dismissed outright or with an advisory letter; how many were sent out for peer review; and how often the peer reviewers disagreed, both entirely and partially.

As previously discussed, CHRC requirements have caused some confusion among licensees. Further, the board has found that out-of-date information, such as inaccurate mailing addresses or changed names, may hinder its ability to communicate with a licensee about an incomplete CHRC.

Recommendation 14: To improve compliance with the requirement to complete a criminal history records check, the board should conduct outreach to licensees to fully communicate what is required to submit to a CHRC. Outreach should include information regarding frequent barriers to compliance, such as out-of-date information, and focus on individuals in license categories with low rates of full compliance.

As of July 1, 2018, prescribers are required to query the Prescription Drug Monitoring Program (PDMP) regarding a patient's history of dispensed controlled dangerous substances before prescribing a monitored drug, with specified exceptions. Prescribers must continue to query PDMP every 90 days thereafter while the course of treatment continues, with limited exceptions. Although these requirements exist in statute, MBP lacks the ability to enforce compliance.

Recommendation 15: Statute should be amended to add a disciplinary ground for physicians and physician assistants for failure to comply with the requirements of Maryland's Prescription Drug Monitoring Program.

Statute only allows the board to impose a reprimand, probation, suspension, and/or revocation, but it does not allow the board to impose any terms and conditions on that disciplinary sanction, unless the respondent agrees to the limitations as part of a consent order – usually in exchange for receiving a lesser disciplinary sanction. Further, board regulations establish that a fine cannot serve as a substitute for a sanction. This is to prevent the image that a respondent is

"buying" his or her way out of further disciplinary action.

Recommendation 16: Statute should be amended to allow the board to impose terms and conditions on a licensee in addition to a disciplinary sanction and to allow the board to impose a fine only in addition to another type of sanction.

During the course of this sunset evaluation, DLS found inconsistencies regarding the application of good moral character as a standard for initial licensure, renewals, and reinstatements. Furthermore, crimes involving moral turpitude had inconsistent requirements for action across different allied health professions.

Recommendation 17: Statute should be amended to make good moral character a requirement for all license types for initial licensure, license renewal, and license reinstatement. Statute should also be amended to authorize the board to deny a license for all allied health applicants if the applicant is convicted of a crime involving moral turpitude. Finally, statute should be amended to make provisions governing polysomnographers and perfusionists and crimes involving moral turpitude consistent with the disciplinary requirements of other allied health practitioners.

Legislation implementing the Interstate Medical Licensure Compact added a disciplinary ground for physicians who fail to comply with other state or federal laws pertaining to the practice of medicine. However, this legislation is scheduled to terminate in 2022, which would also eliminate this disciplinary ground. The legislation also did not apply this disciplinary ground to PAs.

Recommendation 18: Statute should be amended to remove the termination provision related to the disciplinary ground for physicians for failure to comply with any other state or federal law pertaining to the practice of medicine. Statute should be further amended to add a disciplinary ground for physician assistants for failure to comply with any other state or federal law pertaining to the practice of medicine for consistency with the disciplinary grounds for physicians.

In discussions with DLS, MBP highlighted several complaints received of individuals mispresenting themselves as physicians. Currently, the board cannot issue a cease and desist order upon initial receipt of a misrepresentation complaint and must wait until the individual practices medicine without a license.

Recommendation 19: Statute should be amended to authorize the board to issue a cease and desist order against an individual who misrepresents themselves to the public that they are authorized to practice medicine in Maryland.

During the course of this sunset evaluation, DLS encountered instances in which board meeting agendas were not posted prior to public meetings. Further, while full board meeting agendas indicate that some portion of the meeting will be closed, DLS observed at least one allied health advisory committee meeting that planned for and held a closed session without public notice.

Recommendation 20: To ensure transparency and compliance with the Open Meetings Act, the board should ensure that meeting agendas are posted on the board's website prior to the board or allied health advisory committee meeting. The board should further ensure that the agendas reflect whether the board or allied health advisory committee may be meeting in closed session.

DLS observed extensive board member training; however, despite this training, some members expressed a lack of familiarity with the functionality of the iPads used during meetings. Both board members and allied health advisory committee members expressed a desire for training early in their appointment.

Recommendation 21: To enhance the early effectiveness of new board members and members of allied health advisory committees, board staff should ensure that new members receive a brief training session within one month of appointment, including a focus on the functionality of board-issued devices used for reviewing and accessing board-related materials.

ATAC is the largest allied health advisory committee with 11 members, 3 of which are outside of the athletic training profession (1 chiropractor, 1 physical therapist, and 1 occupational therapist). DLS found that the size of ATAC can make it difficult to achieve a quorum for meetings. DLS also received feedback through the licensee survey and from the Maryland Athletic Trainers' Association that athletic trainers would prefer to minimize the number of individuals who represent outside professions on the committee.

Recommendation 22: Statute should be amended to consolidate the chiropractor, physical therapist, and occupational therapist members of the Athletic Trainer Advisory Committee to one representative from these three professions, reducing the total number of members on the advisory committee from 11 to 9.

Several allied health advisory committees require board members to also serve on an allied health advisory committee. This not only puts additional requirements on volunteer board members but is also largely unnecessary due to the board granting final approval on actions of the advisory committees.

Recommendation 23: Statute should be amended to remove the requirement that a physician member of the board serve on the Physician Assistant Advisory Committee and Naturopathic Medicine Advisory Committee and instead allow any licensed physician to fill this role. Statute should be further amended to remove the requirement that a board member serve on the Radiation Therapy, Radiography, Nuclear Medicine Technology, and Radiologist Assistance Advisory Committee.

During the course of this evaluation, DLS noted that the Polysomnography Professional Standards Committee cancelled their scheduled meetings due to lack of agenda items. It was expressed that this is not uncommon for this advisory committee. DLS received feedback that similarities in the work of polysomnographers and respiratory care practitioners could make it more efficient for the two committees to be combined.

Recommendation 24: The board, in consultation with the Polysomnography Professional Standards Committee and the Respiratory Care Professional Standards Committee, should study the powers and duties of the Polysomnography Professional Standards Committee. In its fiscal 2020 annual report, the board should discuss the results of this study and make recommendations on whether to alter the duties of the Polysomnography Professional Standards Committee, abolish the Polysomnography Professional Standards Committee, or combine the Polysomnography Professional Standards Committee with the Respiratory Care Professional Standards Committee or another allied health advisory committee.

Currently, the executive director and board chair are required to be bonded in an amount fixed by the board. Generally, the purpose of imposing a bonding requirement is to protect clients or consumers from financial losses. The executive director and board no longer directly handle licensing payments, however, making the requirement unnecessary. All other health occupations boards have removed this requirement.

Recommendation 25: Statute should be amended to repeal the requirement that the executive director and board chair be bonded.

During this evaluation, board staff made DLS aware of additional statutory provisions that have inconsistent language, typographical errors, obsolete references, or are redundant.

Recommendation 26: Statute should be amended to make nonsubstantive corrections and codify existing board practices.

The survey conducted by DLS elicited written feedback from licensees based on their recent interactions and experiences with the board. The most common comment provided to DLS was instances of various negative customer service interactions with board staff.

Recommendation 27: The board should continue to improve communication with licensees and the public through training and policies to ensure phone and email inquiries receive prompt responses.

MBP and its related allied health advisory committees have continued to progress since the last DLS sunset evaluation in 2016. The board functions well and meets its statutory missions. In addition, MBP has implemented the recommendations included in the 2016 evaluation or otherwise addressed the issues raised at that time.

MBP and its committees are supported by dedicated board and allied health advisory committee members and staff. MBP plays a key role in protecting the public health and welfare, and there is no question that the board and its allied health advisory committees should continue to exist. Absent action during the 2020 legislative session, MBP and associated statutes (except for PAs) will terminate June 1, 2020. Based on these findings, DLS recommends that the termination dates of MBP and its allied health advisory committees be extended for 10 years and one month.

Recommendation 28: Statute should be amended to extend the termination date for the State Board of Physicians and its related allied health advisory committees to July 1, 2030.

Chapter 1. Introduction and Background on the State Board of Physicians

Primary Recommendation:	**Extend the termination dates of the State Board of Physicians and the related allied health advisory committees by 10 years and one month until July 1, 2030.**

Date Established:	2003 (replaced State Board of Physician Quality Assurance)
Most Recent Prior Evaluation:	Full evaluation, 2016
	Primary recommendation: Extend termination dates by five years until July 1, 2023. Limit scope of next sunset to evaluating (1) implementation of recommendations made in the 2016 report; (2) the efficacy of the two-panel disciplinary system; and (3) the impact of criminal history records checks on the board and licensees
Date of Evaluation Changed:	Chapter 419 of 2019 advanced the termination date of the board and the related allied health advisory committees (with the exception of the Physician Assistants Advisory Committee) to June 1, 2020
Composition:	22 members (14 physicians; 1 representative of the Maryland Department of Health; 1 physician assistant; 6 consumers, including 1 public member knowledgeable in risk management or quality assurance)
Staff:	68.5 authorized positions, including board staff (55.5) and Office of the Attorney General positions (13). As of October 2019, the board has 3 vacancies, 11 contractual positions, and 3 temporary employees
Active Regulated Professions:	Physicians (31,426), physician assistants (3,629), radiographers (6,229), respiratory care practitioners (2,795), athletic trainers (781), polysomnographers (367), perfusionists (118), naturopathic doctors (46), and psychiatric assistants (5)
Authorizing Statute:	Titles 14 and 15, Health Occupations Article

The Sunset Review Process

This evaluation was undertaken under the auspices of the Maryland Program Evaluation Act (§ 8-401 *et seq.* of the State Government Article), which establishes a process better known as "sunset review" because most of the agencies subject to review are also subject to termination.

The State Board of Physicians (MBP) and its allied health advisory committees last underwent evaluation as part of sunset review in 2016. The Department of Legislative Services (DLS) offered 19 recommendations related to licensing, complaint processing, criminal history records checks (CHRC), and other issues. DLS recommended that the termination dates for MBP and the allied health advisory committees be extended for five years to July 1, 2023, and recommended limiting the scope of the next sunset evaluation to assessing (1) implementation of recommendations made in the 2016 report; (2) efficacy of the two-panel disciplinary system; and (3) impact of CHRCs on the board and licensees.

Although scheduled for evaluation in 2021, Chapter 419 of 2019 advanced the termination dates of MBP and the related allied health advisory committees (with the exception of the Physician Assistants Advisory Committee) to June 1, 2020, and required an evaluation by DLS during the 2019 interim.

This evaluation was undertaken to provide the Maryland General Assembly with information on making the determination about whether to reauthorize MBP and its advisory committees and for what period of time. Recommendations are made throughout this document.

Evaluation Methodology

In conducting this evaluation of MBP, DLS reviewed board-related statutes, regulations, and annual reports; attended disciplinary panel and advisory committee meetings; conducted an online survey of MBP licensees; and conducted interviews with interested parties, including board and allied health advisory committee members, key board staff, board counsel, and representatives of professional associations representing occupations licensed by MBP.

Report Structure

This report consists of six chapters. **Chapter 1** offers an overview of the sunset process, an update on the board's implementation of the recommendations from the 2016 sunset review, background on MBP, and a summary of legislative changes to the board since the last sunset review. **Chapter 2** discusses the board's licensing and renewal processes. Complaint and disciplinary issues are discussed in **Chapter 3**. **Chapter 4** discusses administrative issues. **Chapter 5** provides a review of the licensee survey conducted as part of this sunset evaluation. **Chapter 6** is a brief conclusion.

As supplements to the report, six appendices are included. **Appendix 1** contains draft legislation to implement the statutory recommendations contained in this report. **Appendix 2** contains a summary of recommendations from the 2016 full sunset review and the outcome associated with those recommendations. **Appendix 3** shows physician licensing fees by state. **Appendix 4** shows medical board membership by state. **Appendix 5** contains the text and detailed results of the licensee survey. MBP reviewed a draft of this report and provided the written comments included as **Appendix 6**. Appropriate factual corrections and clarifications have been made throughout the document; therefore, references in written comments may not reflect this published version of the report.

Duties and Composition of the State Board of Physicians

MBP is charged with enforcing the Maryland Medical Practice Act and the Maryland Physician Assistants Act. Among its duties, MBP must (1) adopt regulations to carry out the provisions of law for which it is responsible; (2) establish policies for board operations; (3) oversee licensing of physicians and allied health professionals; (4) review and investigate complaints; (5) report on all disciplinary actions, license denials, and license surrenders; (6) appoint members of the disciplinary panels; and (7) develop and approve an annual report.

As shown in **Exhibit 1.1**, in fiscal 2019, the board issued more than 28,000 new and renewal licenses to physicians and multiple categories of allied health professionals. Due to the biennial renewal cycle, the board actually had regulatory authority over a total of more than 45,000 individuals in fiscal 2019. In that same year, the board dealt with 1,190 complaints.

Exhibit 1.1
Licensing Activity for the State Board of Physicians
Fiscal 2016-2019

	2016	2017	2018	2019
Physicians				
New	1,964	1,749	2,011	1,968
Renewal	12,814	15,748	13,044	15,507
Physician Assistants				
New	377	305	399	363
Renewal[1]	–	3,201	–	3,585
Radiographers				
New	361	438	343	283
Renewal[1]	–	5,903	–	6,096
Respiratory Care Practitioners				
New	176	170	136	142
Renewal[2]	2,688	–	2,579	–
Polysomnographers				
New	22	29	18	14
Renewal[1]	54	363	–	361
Athletic Trainers[3]				
New	127	96	111	128
Renewal[2]	505	–	567	–
Perfusionists				
New	27	6	16	25
Renewal[2]	73	–	79	–
Naturopathic Doctors				
New	21	9	13	7
Renewal[2]	–[4]	–	33	–
New Licenses	3,075	2,802	3,047	2,930
Renewal Licenses	16,134	25,215	16,302	25,549
Total Licenses	19,209	28,017	19,349	28,479

[1] Physician assistants, radiation therapists, radiographers, nuclear medicine technologists and radiologist assistants, athletic trainers, and polysomnographers renew in odd-numbered calendar years only.
[2] Respiratory care practitioners, perfusionists, and naturopathic doctors renew in even-numbered calendar years only.
[3] Athletic trainers renew by September 30 of odd-numbered calendar years, which falls in even-numbered fiscal years.
[4] The licensing requirement for naturopathic doctors went into effect on March 1, 2016.

Source: State Board of Physicians Annual Reports: Fiscal 2016, 2017, and 2018; State Board of Physicians

MBP is composed of 22 members. By statute, the membership is as follows:

- 11 practicing licensed physicians, including 1 doctor of osteopathy, appointed in accordance with a statutory nominating process;
- 1 practicing licensed physician appointed at the Governor's discretion;
- 2 practicing licensed physicians with full-time faculty appointments who serve as representatives of academic medical institutions and are appointed from lists of names submitted by The Johns Hopkins University School of Medicine and the University of Maryland School of Medicine;
- 1 representative from the Maryland Department of Health nominated by the Secretary;
- 1 licensed physician assistant (PA) appointed at the Governor's discretion in accordance with a statutory nominating process;
- 5 consumer members; and
- 1 public member knowledgeable in risk management or quality assurance matters appointed from a list submitted by the Maryland Hospital Association.

All board members serve staggered four-year terms. No member may serve more than two consecutive full terms. The Governor appoints a chair and, from among its members, the board elects any other officers that the board considers necessary. The chair of the board assigns each board member to a disciplinary panel and selects a member of each panel to be chair of the disciplinary panel. In practice, the board chair also serves as chair of one of the disciplinary panels.

The Board Regulates Multiple Allied Health Professions

Statutory provisions place several allied health professions under the jurisdiction of MBP and establish seven allied health advisory committees that assist MBP in its oversight role. These committees comprise representatives of the regulated professions, physicians, and consumers. The allied health professions under the jurisdiction of MBP are (1) PAs; (2) radiographers, radiation therapists, nuclear medicine technologists, and radiologist assistants; (3) respiratory care practitioners; (4) polysomnographic technologists; (5) athletic trainers; (6) perfusionists; and (7) naturopathic doctors.

Previous Sunset Recommendations Largely Implemented by the Board

As discussed earlier, DLS' 2016 sunset review of MBP made a variety of recommendations, the majority of which were enacted by Chapters 217 and 218 of 2017. In addition to the statutory changes made through these Acts, other changes were made administratively or by regulation. The outcome of each recommendation is shown in Appendix 2. Of the 19 DLS recommendations, MBP agreed with 16 and modified 1 (to allow for inclusion of the information in its annual report), while disagreeing with 2. Chapters 217 and 218 reflected MBP's suggested modification and did not include the rejected recommendations.

Major Legislative Changes Since the 2016 Sunset Review

Since the 2016 sunset review, several statutory changes have affected MBP and/or the professions regulated by the board. Most notably, Chapter 570 of 2017 requires a health care provider to prescribe the lowest effective dose of an opioid in a quantity that is no greater than that needed for the expected duration of pain severe enough to require an opioid with some exceptions. This requirement does not apply to an opioid prescribed to treat a substance-related disorder; pain associated with a cancer diagnosis; pain experienced while the patient is receiving end-of-life, hospice, or palliative care services; or chronic pain. A practitioner who fails to comply with these prescribing requirements may be subject to disciplinary action by their respective health occupations board.

Chapter 610 of 2017 authorizes a health care practitioner who provides behavioral health services and is licensed in the State by certain health occupations boards to use teletherapy if the practitioner complies with specified requirements. Chapter 610 required the boards to adopt regulations that, to the extent practicable, are uniform and nonclinical, for the use of teletherapy by health care practitioners.

Chapters 442 and 443 of 2018 authorize a PA to personally prepare and dispense a drug that the PA is authorized to prescribe under a delegation agreement if (1) the supervising physician possesses a dispensing permit; and (2) the PA only dispenses drugs within the supervising physician's scope of practice and within the scope of the delegation agreement. Chapter 470 of 2018 enters Maryland into the Interstate Medical Licensure Compact for physicians. Major legislative changes are shown in **Exhibit 1.2**.

Exhibit 1.2
Major Legislative Changes Affecting the State Board of Physicians Since the 2016 Full Sunset Review

Year	Chapter(s)	Change
2017	183	Requires the Maryland Department of Health, in consultation with the Maryland Department of Veterans Affairs, to provide specified health occupations boards a list of recommended courses in military culture.
2017	217/218	Extend the termination date of the board from July 1, 2016, to July 1, 2023, and make substantial changes to the laws governing physicians and allied health professionals.
2017	546/547	Prohibit the board from requiring, as a qualification for initial licensure or a condition of license renewal, (1) certification by a nationally recognized accrediting organization that specializes in a specific area of medicine or (2) maintenance of such certification that includes continuous reexamination to measure core competencies as a requirement for maintaining certification.
2017	570	Requires a health care provider, on treatment for pain and based on the clinical judgment of the provider, to prescribe the lowest effective dose of an opioid and a quantity that is no greater than that needed for the expected duration of pain severe enough to require an opioid that is a controlled dangerous substance, with specified exceptions.
2017	610	Authorizes certain health care practitioners who provide behavioral health services and are licensed in the State to use teletherapy if they comply with specified requirements.
2017	770	Requires the public practitioner profile maintained by the board to include information on whether a physician maintains medical professional liability insurance, as reported by the physician. Each licensed physician must (1) notify a patient in writing if the physician does not carry professional liability insurance coverage or if the physician's coverage has lapsed and not been renewed and (2) if the physician does not carry professional liability insurance coverage, conspicuously post such information where the licensee practices.
2018	215/216	Require a health care provider, when prescribing an opioid, to advise the patient of the benefits and risks associated with the opioid. When coprescribing a benzodiazepine with an opioid, a health care provider must advise the patient of the benefits and risks associated with the benzodiazepine and the coprescription of the benzodiazepine.

Year	Chapter(s)	Change
2018	442/443	Authorize a physician assistant (PA) to personally prepare and dispense a drug that the PA is authorized to prescribe under a delegation agreement if (1) the supervising physician possesses a dispensing permit; and (2) the PA only dispenses drugs within the supervising physician's scope of practice and within the scope of the delegation agreement.
2018	470	Enters Maryland into the Interstate Medical Licensure Compact for physicians. The provisions terminate September 30, 2022.
2018	569	Requires a health occupations board to send, by first-class mail, a renewal application at the request of a licensee, permit holder, certificate holder, or registrant, if the board otherwise sends renewal notices or other specified documents exclusively by email.
2019	419	Advances, from July 1, 2023, to June 1, 2020, the termination date of the board and the allied health advisory committees. Advances, from 2021 to 2019, the date of the next full evaluation of the board under the Maryland Program Evaluation Act.
2019	425	Prohibits a health care practitioner or a student or trainee in a program to become a health care practitioner from performing a pelvic, prostate, or rectal examination on a patient who is under anesthesia or unconscious except under certain circumstances.
2019	445	Authorizes a licensed physician to delegate duties to a "registered cardiovascular invasive specialist" assisting in a fluoroscopy under specified conditions. The provisions terminate September 30, 2024.

Source: Laws of Maryland

Chapter 2. Licensing Issues

Licensing is one of the core functions of the State Board of Physicians (MBP). With the authority to issue and revoke licenses and impose discipline on licensees, the board can enforce standards of care for physicians and allied health professionals. The Department of Legislative Services (DLS) found that the board consistently meets and often exceeds its licensing performance goals for physicians, outperforming all other large health occupations boards, and has continued its work to improve the licensing process. However, statutory changes could further expedite the process by which athletic trainers may begin practice. Additional exceptions to licensure would allow practitioners in certain specialized cases to practice without approval from the board. Furthermore, the criminal history records check (CHRC) requirement for licensees applying for renewal and reinstatement could be further clarified.

The Board Issues a Variety of Licenses

As shown in Chapter 1, Exhibit 1.1, the board issues a variety of licenses. The latest addition to the board's regulatory authority was added under Chapters 153 and 399 of 2014, requiring licensure of naturopathic doctors beginning March 1, 2016. Licensing figures for each license type have remained relatively stable, with physicians, physician assistants (PA), and radiographers representing the largest licensing categories.

MBP follows a biennial renewal cycle for licensees. Physicians are staggered by last name so that approximately half of licensees renew each calendar year. In the allied health professions, PAs, polysomnographers, athletic trainers, and radiographers renew in odd-numbered calendar years, while respiratory care practitioners, perfusionists, and naturopathic doctors renew in even-numbered calendar years. Specific renewal dates are further staggered throughout the calendar year to distribute workflow for board staff. The board's website allows licensees to submit applications for license renewal online. Respondents to the licensee survey, discussed further in Chapter 5, were particularly enthusiastic about the ease of online license processing.

Statute requires the board to send a renewal notice to licensees at least one month prior to license expiration. The board then only allows online license renewals during the window between this notice and the license expiration date. In several survey comments, respondents noted that a longer renewal window (one that begins prior to the notice being sent) would be helpful for those licensees who are already aware of their license expiration date and prefer to plan ahead. Changing this timeframe would not impact the requirement for, or timing of, the renewal notice. Given the expectedly few licensees who would utilize this option before receiving notice, it should have a minimal impact on the distribution of the board's renewal processing workload.

Recommendation 1: The board should allow a licensee to complete an online license renewal at any time during the 90 days immediately preceding license expiration.

Licensee Public Profile Information Could Be Made More Clear

Much of the information received by the board in an initial license or renewal application is posted to the licensee's public Internet profile created and maintained by the board. Section 14-411.1 of the Health Occupations Article requires the online profile to include specific information about the licensee, including the number of medical malpractice final court judgments and arbitration awards against the licensee, within the most recent 10-year period for which all appeals have been exhausted as reported to the board. This provision does not specify the source of the malpractice information. Certain other education and practice information required in statute to be posted to the profile, however, specifies that it is "reported to the board by the licensee."

Board staff has expressed concern that malpractice lawsuits are not always reported to the board, thereby making this profile category unreliable for the public. A description of "none reported" on a practitioner's profile may not accurately reflect whether a licensee has had an adverse judgment. Adding a note that the malpractice information is "as reported by the licensee" would signal to the public that the accuracy of the information has not been independently verified by the board.

Recommendation 2: Statute should be amended to require a licensee profile to specify that malpractice information is "as reported to the board by the licensee."

Physician Licensing Fees Are Comparable to Other States' Fees

As of October 2019, physician initial licensing fees were $790 and renewal fees were $486, paid every two years. As shown in Appendix 3 at the end of this report, while these fees tend toward the higher end of the fee scale nationally, they are also comparable to those in a number of states and the District of Columbia. Considering licensing fees on an annual basis, the average initial fee is $289, and the average renewal fee is $221. For Maryland, these figures are $395 and $256, respectively. Measured on an annualized basis, 12 states have higher initial licensing fees than Maryland, and 11 have higher renewal fees.

The Board Consistently Exceeds Licensing Performance Goals

The Maryland Department of Health (MDH) establishes goals for all health occupations boards to issue new licenses or process license renewals. For MBP, these goals are set at 10 and 5 business days of receiving the last qualifying document, respectively. MDH aims to have each health occupations board meet that standard for 95% of licensees each year. MBP has consistently met this goal and exceeded it by renewing 100% of licenses in 5 days or fewer in fiscal 2017, 2018, and 2019. For each respective fiscal year, the board issued 98%, 99%, and 98% of new licenses in 10 days or fewer. MBP's particularly efficient processing of renewals is in large part due to the online renewal processing.

In exceeding its licensing performance goals, MBP consistently outperforms other similarly sized boards. Along with MBP, the five largest boards are the Maryland Board of Nursing, the State Board of Pharmacy, the State Board of Social Work Examiners, and the State Board of Dental Examiners. MBP processed the second highest number of renewals each year during the last five years (second to the Maryland Board of Nursing) and is among the top three boards for issuing new licenses in a timely manner. All five boards follow a biennial renewal cycle. The Maryland Board of Nursing is the only other large board that has exceeded its performance goals for new license issuing in each of the last three fiscal years, though it did not meet these goals for any year in license renewals. The State Board of Social Work Examiners, conversely, met its performance goals for each of the past three years in license renewals but not for issuing new licenses. No other large board has met these goals across both categories in each year.

Criminal History Records Check Requirements Should Be Clarified

In 2014, MBP began developing a proposal to require CHRCs after it was discovered that a Maryland physician had been practicing in the State for almost two decades despite having previously served a prison sentence for rape in Florida in 1987; the physician served 4 years of a 10-year sentence and began practicing medicine in Maryland in 1996. The physician was charged with sexually assaulting a patient in Maryland in 2014. The charges were eventually dropped ahead of the scheduled criminal trial after the physician agreed to surrender his medical license.

Chapter 34 of 2015 required applicants and licensees of MBP to submit to a CHRC as a qualification for licensure and created new grounds for disciplinary action if a licensee failed to submit to a CHRC. The board began requiring CHRCs for applicants for initial licensure and for renewal and reinstatement on October 1, 2016. Thirty-nine other states and the District of Columbia require CHRCs for physician licensing, while 3 additional states require a CHRC for those physicians who obtain a state license through the interstate compact, discussed below. The board may renew a license if the licensee attests that they have submitted to a CHRC.

On receipt of CHRC information, the board must consider the following factors in determining whether to grant or reinstate a license: (1) the age at which the crime was committed; (2) the nature of the crime; (3) the circumstances surrounding the crime; (4) the length of time that has passed since the crime; (5) subsequent work history; (6) employment and character references; and (7) other evidence that demonstrates whether the applicant poses a threat to public health or safety. The board may consider these factors in determining whether disciplinary action should be taken against a licensee who has renewed.

As discussed further in Chapter 3, the board has disciplined a number of licensees for failure to submit the required CHRC at the time of license renewal. Board staff indicates that a number of licensees go through the initial steps by submitting fingerprints but do not complete the process (*i.e.,* the fingerprints are illegible or a previously unreported name change yields incomplete results). In these instances, the board is unclear as to its authority to act based on the failure of a licensee to *complete* the process.

Recommendation 3: Statute should be amended to require an applicant for licensure or license renewal to *complete*, rather than *submit to*, a criminal history records check. Statute should be similarly amended to allow the board to discipline a licensee for failure to *complete* a criminal history records check.

Out-of-state Licensees Have Two Methods of Licensure

Physicians licensed outside of Maryland have two pathways to expedite obtaining a Maryland license. First, Chapters 460 and 461 of 2016 required MBP to license an applicant to practice medicine in Maryland if the applicant (1) became licensed as a physician in another jurisdiction under requirements substantially equivalent to Maryland licensing requirements, as determined by MBP; (2) is in good standing under the laws of the other jurisdiction; (3) submits the appropriate application to MBP; (4) pays the application fee set by MBP; and (5) the jurisdiction in which the applicant is licensed offers a similar reciprocal licensing process for individuals who are licensed to practice medicine in Maryland. However, at the time of this report, the board has not yet granted a reciprocal license.

Second, Chapter 470 of 2018 entered Maryland into the Interstate Compact on Medical Licensure, providing a streamlined process that allows physicians to become licensed in multiple states and enhancing the portability of a medical license. The bill went into effect July 1, 2019, and terminates September 30, 2022.

Recommendation 4: To better understand the efficacy and efficiency of licensing physicians from out of state, in its 2021 annual report, the board should (1) include an update on licensing by reciprocity and through the Interstate Medical Licensure Compact and (2) make recommendations on whether to continue either or both methods of licensure and whether any statutory changes are needed to accomplish the goal of streamlining licensure for out-of-state physicians.

Continuing Medical Education

In addition to any other qualifications and requirements established by the board, the board may establish continuing medical education requirements as a condition for the renewal of licenses. Chapter 99 of 2016 prohibited MBP from establishing a requirement that every licensed physician complete a specific course or program as a condition for the renewal of a license.

If a complaint is made against a licensee and a disciplinary panel votes to charge the practitioner (disciplinary processes are discussed in greater detail in Chapter 3), the practitioner may opt to enter into a consent order with the board agreeing to certain sanctions. In these instances only, the board may offer the licensee the opportunity to take a particular course as a condition of the consent order. DLS received feedback during this evaluation that some practitioners have encountered courses proposed by the board that are not available online and are no longer offered

in a location convenient for the practitioner. However, board staff reported that, in these instances, a practitioner could respond to the board by presenting this issue and be offered an alternative course option. Some practitioners may be unaware of their ability to satisfy the terms of their consent order and, therefore, fail to pursue this alternative.

Allied Health Licensure Issues

Athletic Trainer License Processing Should Be Streamlined

An individual must be licensed by the board to practice athletic training except under certain circumstances. Athletic trainers may only practice under the supervision of a licensed physician and only in an approved setting. Athletic trainers must enter into a written evaluation and treatment protocol with a licensed physician, and the protocol must be approved by MBP.

Chapters 411 and 412 of 2016 authorized an athletic trainer to assume the duties under an evaluation and treatment protocol after receiving a written recommendation for approval from the Athletic Trainer Advisory Committee (ATAC) if the protocol (1) does not include specialized tasks or (2) includes specialized tasks that have been previously approved by MBP. If the protocol includes specialized tasks that have not been previously approved, an athletic trainer may only perform the specialized tasks after receiving written approval from MBP.

Similar to the process for athletic trainers, PAs also may only practice under the supervision of a licensed physician and may only perform tasks that are authorized in a delegation agreement, which must be filed with the board. Delegation agreements that include specified advanced duties require approval by the board and the Physician Assistant Advisory Committee (PAAC) must recommend to the board whether to approve the delegation agreement with advanced duties. If the delegation agreement does not include advanced duties that require board approval or the advanced duties have been preapproved, the PA may practice on the date the board receives the delegation agreement, and the agreement does not need to be approved by PAAC.

Recommendation 5: To streamline the licensing process for athletic trainers, statute should be amended to authorize an athletic trainer to begin practice on the date that the applicant receives acknowledgement that board staff has received the completed application for an athletic trainer license and accompanying evaluation and treatment protocol appropriate to the scope of practice without first receiving approval from ATAC if the protocol is given preliminary approval by board staff and (1) does not include specialized tasks or (2) includes specialized tasks that have been previously approved by the board.

Laws Governing Evaluation and Treatment Protocols and Delegation Agreements Need Further Clarity

As discussed above, PAs may practice subject to a delegation agreement with a supervising physician. At times applicants submit incomplete delegation agreements or fail to notify the board

when there is a change in the PA's employment circumstances (statute currently only requires that the board be notified if a PA has been terminated for quality of care reasons). Further, board staff noted that it is unclear whether the PA can choose to terminate a delegation agreement unilaterally.

Recommendation 6: Statute should be amended to clarify that a physician assistant may begin practice on the date that the applicant receives acknowledgement that board staff has received the completed delegation agreement. Statute should also be amended to require a physician assistant and supervising physician to notify the board if the physician assistant has been terminated *for any reason*. Finally, statute should be amended to allow a physician assistant to terminate a delegation agreement with a supervising physician.

Both athletic trainers and PAs are required to have physician supervision to practice. Board staff indicates that it is unclear whether the board is authorized to terminate or void an evaluation and treatment protocol or a delegation agreement when there is a change in licensure status for the allied health practitioner or their supervising physician. These changes in licensure status could include the expiration and nonrenewal of either of the licenses, the death of a licensee, discipline of a licensee by suspension or revocation, or the surrender of a license.

Recommendation 7: Statute should be amended to authorize the board to terminate an evaluation and treatment protocol or a delegation agreement when either a supervising physician or an allied health practitioner has a change in licensure status such that they are unable to legally practice and, in the case of a change in licensure status for a supervising physician, there is no acceptable alternate physician available.

National and State Licensing Fees May Be Duplicative

To qualify for licensure as a radiation therapist, radiographer, or nuclear medicine technologist, an individual must, among other requirements, be certified by the American Registry of Radiologic Technologists (ARRT), Nuclear Medicine Technology Certification Board (NMTCB), or another certifying organization approved by MBP. Radiologist assistants must be certified as a radiologist assistant by ARRT. Several respondents to the licensure survey (discussed in Chapter 5) expressed that national certification requirements are redundant to State licensure and require licensees to pay two fees for the ability to practice in Maryland. As of October 2019, the primary application fee for ARRT was $200, the application fee for NMTCB was $175, and the Maryland State license fee was $150.

Similarly, to qualify for a respiratory care practitioner license, an applicant must be certified by the National Board for Respiratory Care or a certifying organization with equivalent certification requirements that has been approved by MBP. As of October 2019, maintaining this certification costs $25 per year, in addition to the biennial Maryland State license fee of $200. PAs, polysomnographic technologists, athletic trainers, and perfusionists also all require national certification as a prerequisite to State licensure.

Recommendation 8: The board should consult with the appropriate allied health advisory committees and review licensure requirements for allied health professionals to determine if

requirements for national certification create opportunities to simplify the State licensing process or reduce State licensing fees for these allied health professionals.

Exceptions to Licensure

Sections 14-302 and 14-302.1 of the Health Occupations Article establish exceptions to physician licensure under certain limited circumstances. The exceptions include a physician who resides in and is authorized to practice medicine by any state adjoining Maryland and whose practice extends into Maryland if (1) the physician does not have an office or other regularly appointed place in Maryland to meet patients; and (2) the same privileges are extended to Maryland licensed physicians by the adjoining state. Board staff noted that this provision was necessary for home health care agencies in Maryland to accept orders from physicians in adjoining states for follow-up care but has caused confusion in recent years. With the advent of telemedicine, some practitioners have interpreted the provision to apply to physicians who treat patients remotely, though this was not intended or contemplated when the provision was enacted. Representatives from the Maryland State Medical Society provided feedback to the board that narrowly tailoring the exception to in-person evaluations would achieve the original intent of the provision. Board staff further advised DLS that a narrowly tailored statute need not be limited by requiring reciprocal provisions in neighboring states.

Recommendation 9: Statute should be amended to clarify and narrowly tailor the exception to licensure for physicians in neighboring states to apply only to a physician ordering home health care services who has performed an in-person evaluation and to remove the requirement for reciprocal provisions in neighboring states.

Section 14-302.1 allows a physician who is licensed and resides in another jurisdiction to practice medicine in a hospital without a license while engaged in clinical training with a licensed physician but first requires a hospital to apply for approval from the board. Board staff has noted that this requirement may delay needed treatment and seems unnecessary when a hospital is taking responsibility for verifying the qualifications of the visiting physician and ensuring the safety of patients.

Recommendation 10: Statute should be amended to authorize a hospital to bring in a physician who is licensed and resides in another jurisdiction to practice medicine without a Maryland license while engaged in clinical training with a licensed physician in Maryland without the need for application to the board. For clarity, statute should be further amended to combine and reorganize the two statutory sections governing exceptions to physician licensure.

A physician who is licensed by and resides in another jurisdiction and who is designated as a team physician by an athletic or sports team based outside Maryland is exempt from State licensing requirements for the exclusive purpose of traveling with and treating a sports or athletic team. Athletic trainers traveling with an athletic or sports team have a similar exception.

As part of their duties, a respiratory care practitioner may be called on to travel with a patient who is being transported to ensure the patient's stable breathing during transport. Though the practitioner is licensed in the state in which the patient begins their journey, on crossing the Maryland border, the practitioner begins practicing without a license.

Recommendation 11: Statute should be amended to create an exception to licensure to allow a respiratory care practitioner licensed outside the State to practice respiratory care on a patient who is being transported into Maryland.

Chapter 3. Complaints and Discipline

One of the State Board of Physician's (MBP) core functions in protecting the public is to investigate complaints and take disciplinary action against an individual found to be in violation of the Maryland Medical Practice Act, laws governing allied health professionals, or board regulations. This chapter focuses on these functions and assesses the board's implementation of key recommendations from the 2016 sunset evaluation relating to the complaint resolution process. Throughout this evaluation, the Department of Legislative Services (DLS) found that the board has implemented the recommendations from the 2016 sunset evaluation pertaining to complaints and disciplinary actions in a timely and efficient manner. However, the board faces some challenges with compliance for criminal history records checks (CHRC), discrepancies in certain charging grounds, concerns regarding the use of peer review, and infrequent reporting by outside entities.

Overview of the Complaint Resolution Process

Either of MBP's 11-member disciplinary panels, on the affirmative vote of a majority of the quorum of the panel, may reprimand a licensee, place a licensee on probation, or suspend or revoke a license if a licensee violates certain statutory disciplinary grounds. When a complaint is received, MBP staff conducts a preliminary investigation that typically includes sending a copy of the complaint to the respondent (the subject of the complaint) with a request for a response. The results of the preliminary investigation are presented to the assigned panel that may decide to close the case with no action, close the case with an advisory letter (informal, nonpublic action), or instruct board staff to conduct a full investigation.

The results of a full investigation are presented to the panel, which may (1) close the case with no action; (2) issue a nonpublic advisory letter; (3) offer the respondent a precharge consent order if there is not a factual dispute; or (4) vote to charge the respondent. If the panel votes to charge the respondent, the case is sent to the Office of the Attorney General (OAG), which then prepares and serves the respondent with a charging document. Once charged, the respondent is given the option to attend a case resolution conference, referred to as the Disciplinary Committee for Case Resolution (DCCR) – a voluntary, informal, and confidential proceeding before the panel. If no agreement is reached (or if the respondent declines to participate in DCCR), the case is referred to the Office of Administrative Hearings (OAH) for a hearing before an administrative law judge (ALJ).

An OAH hearing is conducted in accordance with the Administrative Procedure Act. An ALJ issues proposed findings of fact, law, and disposition, but the board is not bound by these findings. The administrative prosecutor and the respondent have the opportunity to file exceptions (disagreements) with the ALJ's decision, and the opposite board panel (*i.e.,* the panel that did not originally handle the case) will consider the exceptions, if any, and issue a final order. If the

respondent disagrees with a panel's final order, the respondent may file a petition for judicial review; however, the panel's order may not be stayed pending review.

Status of Prior Recommendations

The 2016 sunset evaluation of MBP made seven recommendations related to the complaint resolution and disciplinary processes. A complete list of 2016 sunset recommendations and the status of each recommendation can be found in Appendix 2. The board agreed with all of the prior recommendations with the exception of one (Recommendation 9), which stated that the next sunset evaluation of MBP should examine the desirability of shifting proceedings involving the unauthorized practice of medicine, denials of initial licenses, certain denials of renewals or reinstatements, and cease and desist orders from the full board to the disciplinary panels. MBP did not concur as it did not want to wait until 2023 to move these types of cases to the then newly implemented two-panel system. Thus, although the recommendation was rejected, such cases were moved from the full board to the disciplinary panels.

Sexual Misconduct Recommendations Have Been Implemented

The 2016 report included two recommendations related to sexual misconduct allegations. The first recommendation (Recommendation 7) was that the board should ensure sexual misconduct regulations are referenced in order summaries in cases where a licensee was specifically found to have violated them. Additionally, the recommendation requested a follow-up report on the feasibility of describing the underlying sexual misconduct in order summaries or other steps the board could take to make it easier for the public to determine whether a case involved sexual misconduct.

In the 2016 sunset evaluation, DLS recommended greater transparency regarding communicating to the public that a violation included sexual misconduct. Until recently, the board had narrow sexual misconduct regulations and could only charge a licensee if the conclusions of law established by OAG contained a violation of these regulations. The board indicated that reference to the sexual misconduct regulations could only be posted on the board's website if the licensee was found to have violated the regulations. The board also noted that it has communicated to administrative prosecutors the importance of charging sexual misconduct violations when applicable. MBP has further addressed sexual misconduct violations by licensees by amending the relevant regulations to include a broader range of misconduct, notably sexual harassment of employees and colleagues. The board reports that these updated regulations allow it to discipline a licensee for a broader range of sexual misconduct. The board also conducted an audit of licensees with disciplinary actions, going back to 2016, who were found to have violated the sexual misconduct regulations. Board staff found that all of the order summaries reviewed appropriately referenced violations of the sexual misconduct regulations.

The second recommendation relating to sexual misconduct was to make statutory changes to require the reporting of sexual misconduct cases for each of the health occupations boards. The

most recent report from the Maryland Department of Health (MDH) was submitted to DLS on March 2, 2019, for the period October 1, 2017, to September 30, 2018. Over this period, MBP received 21 complaints alleging sexual misconduct involving 18 individual licensees. Of these complaints, 10 were either closed without action or resulted in informal/nonpublic action.

The board has included findings of sexual misconduct by practitioner category as part of its annual report since fiscal 2018. Per these reports, the board disciplined four physicians in fiscal 2018 and five physicians in fiscal 2019 for findings of sexual misconduct. In fiscal 2019, disciplinary actions resulting from finding sexual misconduct accounted for less than 2% of the board's 254 total disciplinary actions against physicians. MBP has not had any sexual misconduct findings against physician assistants (PA) or other allied health professionals.

Most Complaints Submitted by Patients/Clients

The board has received more than 1,000 complaints annually for each of the past three fiscal years. The board receives complaints from a variety of sources, most frequently from patients or clients (43% of complaints since fiscal 2017). **Exhibit 3.1** shows the sources of complaints received by the board for fiscal 2017 through 2019.

Several sources listed in Exhibit 3.1 are internally generated by the board, including CHRCs, renewal applications, continuing medical education audits, licensure and allied heath units, and dispensing permits.

Another source of a small number of complaints is law enforcement that includes the courts and local law enforcement agencies. Maryland law requires a court to report to the board each conviction of or entry of a plea of guilty or *nolo contendere* by a physician for any crime involving moral turpitude within 10 days after the conviction or entry of the plea. However, the board reports limited and irregular reporting by the courts to the board, as reflected below. To improve the effectiveness of this statutory mandate, the board could increase outreach to the courts to increase understanding of when to report a licensee.

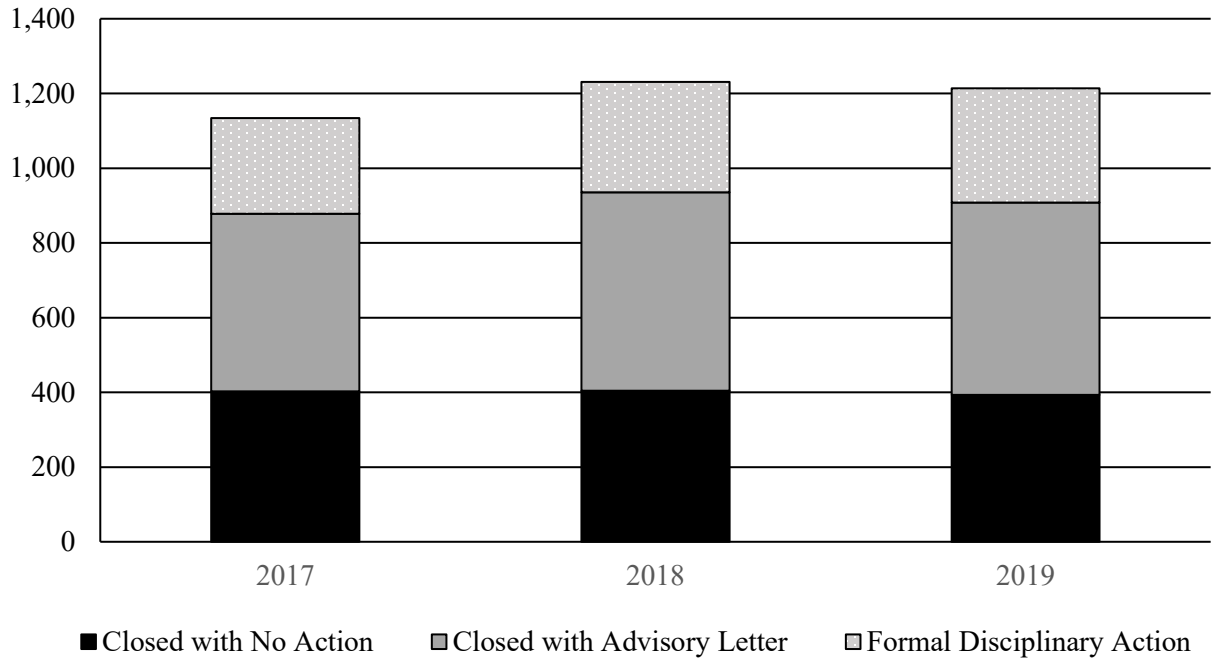
Exhibit 3.1
Sources of Complaints Filed with the Board
Fiscal 2017-2019

Source	2017	2018	2019	Total
Patient/Client	504	494	483	1,481
Criminal History Records Check	156	353	290	799
Board Investigative Review Panel	75	112	85	272
Renewal Application	42	43	76	161
Other	49	28	48	125
Continuing Medical Education Audit	65	18	18	101
Licensure and Allied Health Unit	20	41	38	99
Hospital	30	28	40	98
Anonymous	37	29	31	97
Health Care Practitioner	19	26	30	75
Dispensing Permit	32	6	3	41
Federation of State Medical Boards	16	5	19	40
Child Support Enforcement Agency	5	8	4	17
Law Enforcement	7	3	5	15
Physician Self-reported	5	3	5	13
Office of the Inspector General	1	3	4	8
Out-of-state Board	1	1	3	5
Office of Health Care Quality	1	0	3	4
Division of Drug Control	0	0	4	4
Consumer Protection Agency	1	1	0	2
Media	0	2	0	2
Health Maintenance Organization	1	0	0	1
Drug Enforcement Agency	0	0	1	1
Total	**1,067**	**1,204**	**1,190**	**3,461**

Source: State Board of Physicians

One concern expressed by licensees in the survey conducted by DLS (and discussed further in Chapter 5) was that complaints filed with the board can be frivolous yet result in real consequences for a licensee. The board investigates all complaints submitted to it, regardless of the source or nature. The board's records on disciplinary action show that cases resulted in formal disciplinary action less than 25% of the time in the last three fiscal years. The plurality of complaints received by the board has been resolved with an advisory letter, and nearly a third of complaints have been closed outright. The breakdown of board action since fiscal 2017 is shown in **Exhibit 3.2**.

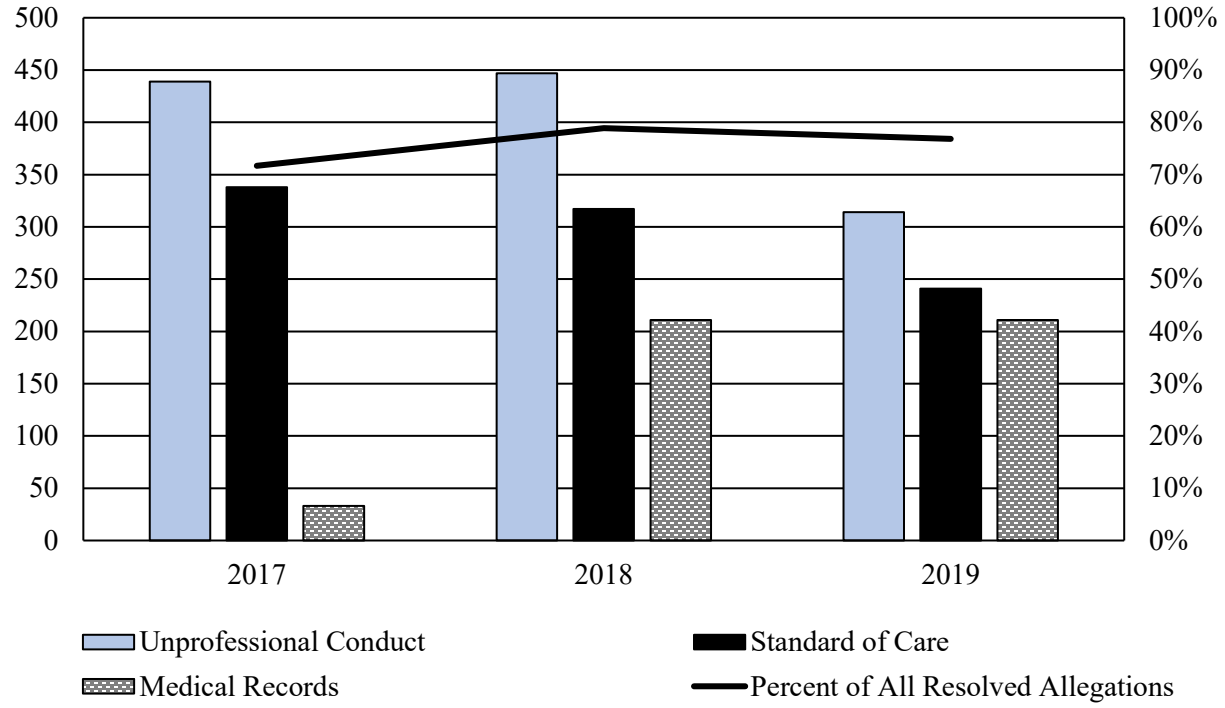
Exhibit 3.2
Complaint Resolution
Fiscal 2017-2019



Source: State Board of Physicians

While the data provided to DLS does not suggest that the board is unjustly disciplining licensees, survey respondents and individuals interviewed by DLS during this evaluation noted how the process of being under investigation by the board is often stressful and burdensome on a licensee, even if it is ultimately closed without formal action. **Exhibit 3.3** shows the three most frequent allegations submitted against physicians. Together, these three categories comprise more than 70% of the allegations against physicians resolved by the board each year.

Exhibit 3.3
Three Most Common Grounds for Complaints Against Physicians
Fiscal 2017-2019



Note:

Short Title	Full Charge Description
Unprofessional Conduct	Is guilty of unprofessional conduct in the practice of medicine.
Standard of Care	Fails to meet appropriate standards of care as determined by peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State.
Medical Records	Fails to keep adequate medical records as determined by appropriate peer review

Source: State Board of Physicians

Two of the most common allegations resolved by MBP, as shown in Exhibit 3.3, require peer reviews of a respondent's charts to determine a violation of the standard of quality medical care. These peer reviews can be particularly stressful for the licensee. While the complaint process generally moves quickly, finding reviewers and conducting peer reviews can be time-consuming

and expensive for the board given that cases involving standard of care require two peer reviews. The respondent is sent a copy of the peer review results and may submit a response within 10 business days. During this sunset evaluation, both in surveys and interviews, DLS found that licensees were concerned about the peer review methodology and the relatively short window within which they could respond to the peer reviews. While there was no consensus on changes to improve the peer review process overall, increasing the time period for responding to the peer review report could make the review process more equitable for both sides of the case while alleviating some of the concerns expressed by licensees.

Recommendation 12: Statute should be amended to allow the board to amend its regulations to increase the amount of time a respondent has to address findings in a peer review from 10 business days to 20 business days for cases of failure to meet appropriate standards of care as determined by peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State.

Peer Review Processes in Standard of Care Cases

During the course of this evaluation, DLS staff received varying feedback related to the peer review process used in standard of care cases. Board staff noted that the 2001 DLS sunset evaluation and the 2012 report conducted by the University of Maryland, Baltimore Campus pertaining to complaint resolution (the Perman Report) both recommended the use of one peer review only.

The board raised concerns regarding the cost of conducting two peer reviews and the challenges of finding qualified peer reviewers for certain specialties. Further, the board highlighted that the Perman Report found regular agreement between the two peer reviewers, and that generally, the disciplinary panel decides not to charge if there are two conflicting peer reviews. MBP also asserts that the board's internal process, which includes review of the complaint by a licensed physician medical consultant, serves as a first review. The disciplinary panel does not submit the case for outside peer review unless it initially finds validity in the standard of care allegations.

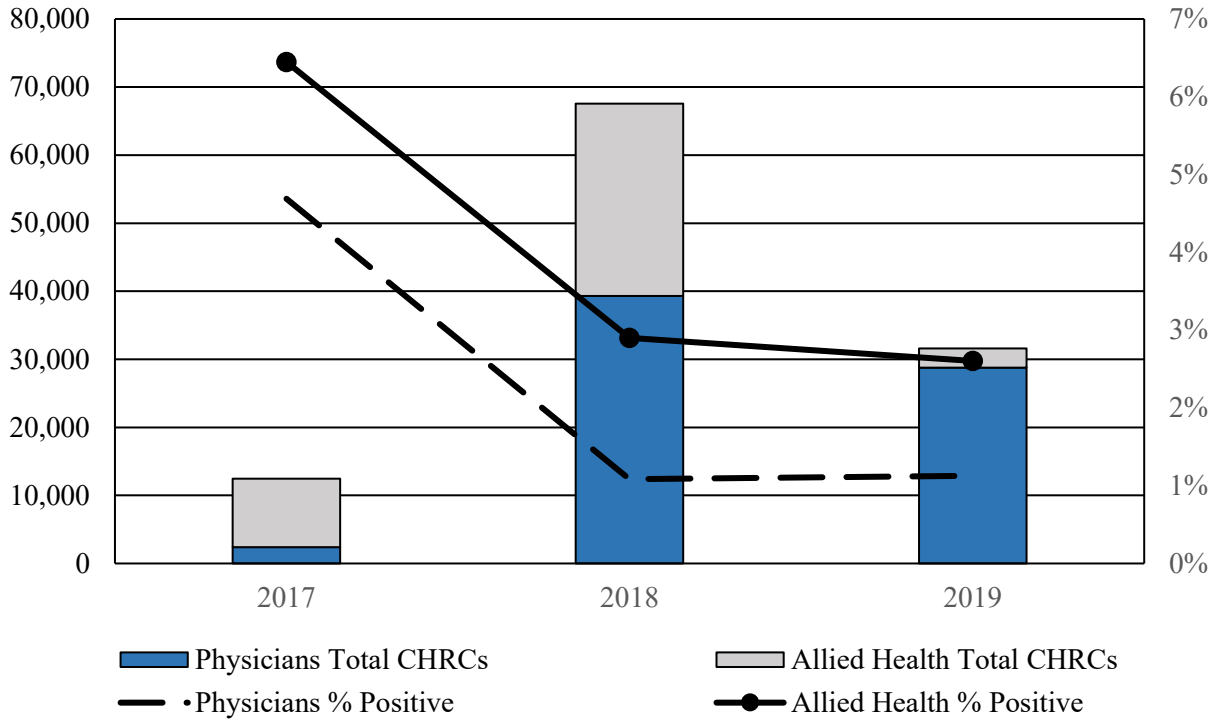
The 2016 sunset evaluation did not make a recommendation on the number of peer reviews for standard of care cases. Given the questions raised regarding the existing processes and understanding that many other factors and stakeholders must be considered in the adjudication of standard of care complaints, DLS staff is not in a position to make a recommendation on the best method of conducting peer reviews. Further, more information is needed regarding the number of instances in which the peer reviews have disagreed in standard of care cases, which has not been fully studied since the Perman Report.

Recommendation 13: Beginning with the fiscal 2020 annual report, the board should include the number of standard of care complaints brought before the board, how many of these complaints were closed outright or with an advisory letter, how many were sent out for peer review, and how often the peer reviewers disagreed – both entirely and partially.

Criminal History Records Check Requirements Result in Disciplinary Action

The board has been required to conduct CHRCs on new licensees, existing licensees upon renewal, and on reinstatement since October 1, 2016. Overall, the board seldom receives positive results (a criminal record is found). As shown in **Exhibit 3.4**, CHRCs return positive findings for less than 3% of allied health professionals and roughly 1% of physicians.

Exhibit 3.4
Total Criminal History Records Checks Conducted and Percentage of Positive Results
Fiscal 2017-2019



CHRC: criminal history records check

Source: State Board of Physicians

The requirement that new and renewal applicants obtain a CHRC took effect October 1, 2016. As physician renewals had already been processed that year, physician renewals were not subject to CHRCs in fiscal 2017. Additionally, fiscal 2017 data includes only nine months of new licensee applicants and allied health renewals subject to CHRCs in the first year. As expected, the first year of CHRCs generated a higher percentage of positive results despite fewer applicants and licensees being subject to CHRCs. Since fiscal 2017, the percentage of positive results has leveled out.

Although the incidence of positive findings is relatively low, as shown in Exhibit 3.1, CHRCs have been the second most frequent driver of complaints in recent years, accounting for 23% of total complaints. Since fiscal 2017, CHRCs have returned 2,405 positive results, 799 of which have resulted in board-generated complaints.

While CHRCs have been an effective tool for the board in identifying the small number of applicants and licensees with criminal records, board staff reports some challenges with CHRC compliance and enforcement. To complete a CHRC for license renewal, the board must provide the fingerprinting form, and the licensee must attest to having completed the form. However, the board reports that numerous licensees are missing their CHRC. **Exhibit 3.5** shows the number of licensees that were missing their CHRC during the most recent renewal period. More than 1,800 licensees were missing CHRCs (4.4% of all renewing licensees). Compliance was particularly low for naturopathic doctors (24.2% were missing CHRCs) and radiographers (6.8% were missing CHRCs).

Exhibit 3.5
Licensees Missing Criminal History Records Checks During Most Recent Renewal Period

Profession	Licensees	Proportion of Renewing Licensees
Physician	1,195	4.2%
Radiographer	399	6.8%
Respiratory Care	108	4.2%
Physician Assistant	65	2.0%
Athletic Trainer	19	3.4%
Naturopathic Doctor	8	24.2%
Polysomnographer	6	1.7%
Perfusionist	3	3.8%
Total	**1,803**	**4.4%**

Source: State Board of Physicians

Board staff identified three main reasons why an individual's CHRC may be missing: (1) a change of name that was previously unreported to the board; (2) rejection/unclear/inability to read initial fingerprints; and (3) failure to submit to a CHRC.

In DLS' survey of licensees, discussed further in Chapter 5, many individuals noted that going to a law enforcement agency or private provider for fingerprints can be onerous or uncomfortable. Further, a licensee disclosed that a fingerprinting firm's labeling mix-up resulted in the board considering the licensee's submission missing.

Ultimately, each missing CHRC requires some degree of follow up by board staff, which can prove difficult if licensees have not updated contact information with the board. Board staff reports uncovering several out-of-date addresses during the CHRC process. The board has issued a reprimand and a $500 fine to individuals who have failed to complete a CHRC but attested to doing so during the renewal of their license. The board indicates that the fine is to maintain consistency between the two panels and increase compliance. MBP staff reports fairly infrequent use of the fine with roughly 30 instances since its inception. Despite this fine, compliance with the CHRC requirement could be improved. Board staff also notes that each missing CHRC case is evaluated independently and can also be dismissed outright or issued an advisory letter rather than the disciplinary action.

Recommendation 14: To improve compliance with the requirement to complete a criminal history records check, the board should conduct outreach to licensees to fully communicate what is required to submit to a CHRC. Outreach should include information regarding frequent barriers to compliance, such as out-of-date information, and focus on individuals in license categories with low rates of full compliance.

The Board Lacks Authority to Impose Discipline for Failure to Follow Prescription Drug Monitoring Program Requirements

Chapter 166 of 2011 established Maryland's Prescription Drug Monitoring Program (PDMP) to monitor the prescribing and dispensing of all Schedule II through V controlled dangerous substances (CDS). Prescribing occurs when a health care practitioner writes a prescription for a CDS, while dispensing occurs when a pharmacist or other licensed dispenser fills the prescription and gives the prescription to a patient. As of July 1, 2017, all licensed pharmacists and all authorized prescribers of CDS (including physicians and PAs) are required to be registered with PDMP. In February 2018, the Office of Controlled Substances Administration in MDH began withholding new or renewal CDS registrations to prescribers who were not registered with PDMP. As of July 1, 2018, prescribers are required to query PDMP regarding a patient's history of dispensed CDS before prescribing a monitored drug with specified exceptions. Prescribers must continue to query PDMP every 90 days thereafter while the course of treatment continues with limited exceptions. Although these requirements exist in statute, MBP lacks the ability to enforce compliance.

Recommendation 15: Statute should be amended to add a disciplinary ground for physicians and physician assistants for failure to comply with the requirements of Maryland's Prescription Drug Monitoring Program.

The Board Cannot Impose Terms and Conditions Outside of Probation or Suspension Unless Respondent Agrees

Board staff highlighted additional challenges when imposing sanctions on a licensee. Currently, statute only allows the board to impose a reprimand, probation, suspension, and/or revocation, but it does not allow the board to impose any terms and conditions on that disciplinary sanction. For instance, in cases where a licensee was found to be overprescribing medications, the board would be unable to limit the licensee's ability to prescribe those medications after the probation or suspension of the licensee has ended. Currently, the board can only impose such terms and conditions outside of the probation or suspension if the respondent agrees to the limitations as part of a consent order – usually in exchange for receiving a lesser disciplinary sanction.

Board staff further noted that respondents in disciplinary matters may seek to have the board impose a fine as a substitute for another sanction. In its regulations, the board has established that a fine cannot serve as a substitute for a sanction. This is to prevent the image that a respondent is "buying" his or her way out of further disciplinary action. Board staff expressed that codifying this policy would strengthen the board's stance on these matters.

Recommendation 16: Statute should be amended to allow the board to impose terms and conditions on a licensee in addition to a disciplinary sanction and to allow the board to impose a fine only in addition to another type of sanction.

Good Moral Character Not Required for Renewal or Reinstatement

Though CHRCs are required for initial, renewal, and reinstatement of licensure, "good moral character" is a requirement for initial licensure only; that standard is not a criteria for license renewal or reinstatement. Thus, the board advises that its authority to act is unclear when a CHRC for a renewal or a reinstated licensee uncovers an instance where a licensee failed to meet a good moral character standard. Board staff raised concerns that this inconsistency could put the public at risk, especially when licensees or individuals with expired licenses commit serious crimes that do not involve the practice of a health occupation and, therefore, the board has no explicit authority to act.

Impact of Crimes Involving Moral Turpitude Inconsistent Across License Types

While Maryland law mandates suspension or revocation of a license for crimes involving moral turpitude for all licensees, only physician and PA applicants can be denied an initial license for these infractions. With the implementation of CHRCs, the board may discover a conviction for

a crime involving moral turpitude but does not have the statutory authority to deny an initial license for other allied health professionals for that finding alone.

Another statutory inconsistency related to crimes involving moral turpitude is that the provisions governing polysomnographers and perfusionists require a hearing for conviction of a crime involving moral turpitude but also require the automatic suspension or revocation of the license. This mandated disciplinary action makes the hearing unnecessary. For physicians and all other allied health professionals, the board must suspend the license and, after completion of the appellate process, if the conviction has not been reversed or the plea has not been set aside with respect to a crime involving moral turpitude, a disciplinary panel must order the revocation of a license on certification by OAG.

Recommendation 17: Statute should be amended to make good moral character a requirement for all license types for initial licensure, license renewal, and license reinstatement. Statute should also be amended to authorize the board to deny a license for all allied health professionals if the applicant is convicted of a crime involving moral turpitude. Finally, statute should be amended to make provisions governing polysomnographers and perfusionists and crimes involving moral turpitude consistent with the disciplinary requirements of other allied health professionals.

Additional Disciplinary Changes

The board noted several instances in which disciplinary grounds are too limited to fully benefit the public. First, legislation implementing the Interstate Medical Licensure Compact added a disciplinary ground for physicians who fail to comply with other state or federal laws pertaining to the practice of medicine. However, the compact's enacting legislation is scheduled to expire in 2022, which would also eliminate this disciplinary ground. Further, the current statute only applies to physicians and not PAs.

Recommendation 18: Statute should be amended to remove the termination provision related to the disciplinary ground for physicians for failure to comply with any other state or federal law pertaining to the practice of medicine. Statute should be further amended to add a disciplinary ground for physician assistants for failure to comply with any other state or federal law pertaining to the practice of medicine for consistency with the disciplinary grounds for physicians.

Second, the board highlighted several complaints received where individuals are mispresenting themselves as physicians to the public. The ability for the board to issue a cease and desist order upon first receipt of such a complaint could protect the public sooner and could also allow the board to issue a cease and desist order in those instances in which actual practice is difficult to prove. Misrepresentation is punishable under § 14-601 of the Health Occupations Article; however, the board cannot issue a cease and desist order in these instances. Instead, the

board must wait until the individual engages in the practice of medicine without a license before it can issue the cease and desist order.

Recommendation 19: Statute should be amended to authorize the board to issue a cease and desist order against an individual who misrepresents to the public being authorized to practice medicine in Maryland.

Chapter 4. Administrative Issues

While there have not been significant administrative changes at the State Board of Physicians (MBP) since the 2016 sunset evaluation, the Department of Legislative Services (DLS) found that there are opportunities to improve the internal functioning of the board and the allied health advisory committees with increased training and changes to committee membership. Consultation with allied health advisory committees could, under certain circumstances, delay action by the board and, in those instances, board action without first consulting the advisory committee may be appropriate. While the board has taken steps to enhance transparency of its operations, the board and advisory committees could improve compliance with the Open Meetings Act. Finally, nonsubstantive statutory changes could bring clarity to the laws governing physicians and allied health professionals.

The Board and Allied Health Advisory Committees

Board Membership Appears Appropriate

The board consists of 22 members: 14 physicians; 1 representative of the Maryland Department of Health; 1 physician assistant (PA); and 6 consumers, including 1 public member knowledgeable in risk management or quality assurance. As discussed in Chapter 3, the board conducts its disciplinary functions through a two-panel system with each panel consisting of 11 members.

Maryland's 22-member board is the second largest medical board among the 50 states and the District of Columbia. Three states (Connecticut, New Jersey, and Washington) follow close behind with 21-members. Nationally, medical board membership ranges from 7 members (Illinois, Indiana, and Louisiana) to 24 members (New York), with an average size of 13. However, if measured by the size of each 11-member disciplinary panel, Maryland would fall in the bottom third of states as one of the smaller boards.

Maryland's neighboring jurisdictions have between 11 and 18 board members – Delaware (16), District of Columbia (15), Pennsylvania (11), Virginia (18), and West Virginia (16). Fourteen states have separate boards for medical doctors and osteopaths (including Pennsylvania and West Virginia). Although a large board, MBP also has greater-than-average consumer representation (6 consumers compared with an average of 3). Again, however, if measured by consumer representation on each disciplinary panel, Maryland's consumer representation is consistent with the national average. Appendix 4 lists the medical board membership for each state.

As discussed in Chapter 3, the two-panel disciplinary system is vital to the board's management of its complaint caseload, allowing MBP to double its work by effectively employing

two boards. DLS has not received any feedback to suggest that altering the board's membership or composition would improve its functionality or efficiency.

The Board and Advisory Committees Should Continue to Improve Transparency

In the 2016 sunset evaluation, DLS noted occasions in which the board had violated the Open Meetings Act by discussing topics in a closed session that are outside of the stated reason for closing the meeting. DLS recommended an increased role for board counsel in advising the board on appropriate topics for discussion in closed sessions. While the board agreed with and is generally complying with this recommendation, in its current evaluation, DLS found that there are further opportunities to improve transparency, particularly with regard to meetings of the allied health advisory committees.

The Open Meetings Act not only requires a stated reason for closing a meeting but also requires the agenda of an open session of a public body to indicate whether the public body expects to close any portion of the meeting. Except in emergency circumstances, statute requires an agenda to be made available to the public as soon as practicable but no later than 24 hours before a meeting.

The board posts meeting schedules, agendas, and minutes on its website. While this information is generally updated in a timely manner, DLS noted several instances in which agendas were not posted prior to public meetings. Further, while MBP agendas indicate that some portion of the meeting will be closed, DLS observed at least one allied health advisory committee meeting that planned for and held a closed session without public notice.

Recommendation 20: To ensure transparency and compliance with the Open Meetings Act, the board should ensure that meeting agendas are posted on the board's website prior to the board or allied health advisory committee meeting. The board should further ensure that the agendas reflect whether the board or allied health advisory committee may be meeting in closed session.

Member Training Could Be Improved

During the course of this evaluation, DLS staff had the opportunity to observe comprehensive training sessions of the full board addressing a variety of topics that the board might encounter. Despite this extensive training, several members expressed a lack of familiarity with the functionality of the iPads used by board members during meetings to reference relevant board documents and case materials. For example, some members were unaware of the bookmark feature enabling easy navigation between case materials. Both board and allied health advisory committee members also expressed a desire for training early in their appointment (which may not coincide with the timing of the training sessions).

Recommendation 21: To enhance the early effectiveness of new board members and members of allied health advisory committees, board staff should ensure that new members

receive a brief training session within one month of appointment, including a focus on the functionality of board-issued devices used for reviewing and accessing board-related materials.

Allied Health Advisory Committee Membership Changes Would Improve the Functioning of the Committees

The Athletic Trainers Advisory Committee (ATAC) is the largest allied health advisory committee, consisting of 11 members appointed by the board: 3 athletic trainers meeting certain requirements; 3 licensed physicians meeting certain requirements; 1 licensed chiropractor; 1 licensed physical therapist; 1 licensed occupational therapist; and 2 consumer members. (The remaining advisory committee membership totals are: PAs – 7; respiratory care – 7; radiation therapy – 10; polysomnographers – 7; perfusionists – 7; and naturopathic doctors – 5.) ATAC is the only advisory committee with members who represent health professions regulated by boards other than MBP.

In discussions with DLS, both board staff and representatives of ATAC raised concerns that the size of ATAC can make it difficult to achieve a quorum for meetings. DLS also received feedback through the licensee survey and from the Maryland Athletic Trainers' Association that athletic trainers would prefer to minimize the number of individuals who represent outside professions on the committee.

Recommendation 22: Statute should be amended to consolidate the chiropractor, physical therapist, and occupational therapist members of the Athletic Trainer Advisory Committee to one representative from these three professions, reducing the total number of members on the advisory committee from 11 to 9.

The memberships of both the Physician Assistant Advisory Committee and Naturopathic Medicine Advisory Committee include one licensed physician who is a member of the board. The Radiation Therapy, Radiography, Nuclear Medicine Technology, and Radiologist Assistant Advisory Committee further requires a member of the board but does not require this member to be a physician. Board staff noted that this adds additional workload to volunteer board members with limited time and can make it difficult to find a physician member willing to serve on both MBP and the advisory committee. Moreover, as matters that go before the advisory committee ultimately go to the board for final approval, this redundancy seems unnecessary.

Recommendation 23: Statute should be amended to remove the requirement that a physician member of the board serve on the Physician Assistant Advisory Committee and Naturopathic Medicine Advisory Committee and instead allow any licensed physician to fill this role. Statute should be further amended to remove the requirement that a board member serve on the Radiation Therapy, Radiography, Nuclear Medicine Technology, and Radiologist Assistance Advisory Committee.

Whenever a new profession is first regulated, there is often a higher workload for its board and staff – answering questions, adopting regulations to govern the profession, and issuing initial licenses. As regulation of a profession is fully implemented, the workload typically decreases. In the case of the board's allied health advisory committees, this has meant that some advisory committees cancel scheduled meetings because the workload no longer supports meeting with the same frequency as when the professions were first regulated.

The Polysomnography Professional Standards Committee represents 367 polysomnographers licensed in the State. The committee scheduled six meetings for calendar 2019. The April and June meetings were both canceled because there were no agenda items to consider. While this is not the only advisory committee to cancel meetings, representatives of this committee in particular noted that a lack of work for the committee was common and expressed that the committee's mission or even the ongoing need for the committee should be evaluated. DLS received feedback that similarities in the work of polysomnographers and respiratory care practitioners could make it more efficient for the two committees to be combined. DLS staff did not receive similar feedback regarding the other advisory committees, and there does not appear to be a need to recommend changes to those committees at this time.

Recommendation 24: The board, in consultation with the Polysomnography Professional Standards Committee and the Respiratory Care Professional Standards Committee, should study the powers and duties of the Polysomnography Professional Standards Committee. In its fiscal 2020 annual report, the board should discuss the results of this study and make recommendations on whether to alter the duties of the Polysomnography Professional Standards Committee, abolish the Polysomnography Professional Standards Committee, or combine the Polysomnography Professional Standards Committee with the Respiratory Care Professional Standards Committee or another allied health advisory committee.

Board Staff and Related Requirements

Board Chair and Executive Director Bonding Requirement Is Outdated

Chapter 627 of 1993 required the executive director and board chair to be bonded in an amount fixed by the board. Generally, the purpose of imposing a bonding requirement is to protect clients or consumers from financial losses. The executive director and board no longer directly handle licensing payments, however, making the requirement unnecessary. MBP is also the only health occupations board for which this requirement is still in effect.

Recommendation 25: Statute should be amended to repeal the requirement that the executive director and board chair be bonded.

Board Relies on Contractual and Temporary Staff

As shown in the board overview in Chapter 1, the board has 68.5 authorized positions and 3 vacancies, representing a 4.4% vacancy rate. Of the 68.5 positions, 13 are employees of the Office of the Attorney General (OAG). Both in interviews with DLS and in board reports, the board has noted that only 4 of the OAG positions are actually assigned to work with MBP. The remaining 9 positions handle work for other boards or programs.

The board has maintained, both in interviews and in its annual reports, that the current staffing level is inadequate to meet its workload. In addition to regulating additional allied health professions, the board's workload has increased with the implementation of criminal history records checks, which involves some manual data entry and processing. The board is meeting these obligations by relying on 11 contractual and 3 temporary staff positions.

Despite these workload concerns, DLS found in Chapter 2 that the board consistently meets its licensing performance goals for physicians and allied health professionals. DLS also found in Chapter 3 that the board generally processes complaints in a timely manner and seems to handle its complaint workload well under the two-panel disciplinary system. The board has the authority to add additional special-funded contractual employees if workload demand increases beyond its current capacity.

Nonsubstantive Statutory Changes Recommended

During this evaluation, board staff made DLS aware of additional statutory provisions that have inconsistent language, typographical errors, obsolete references, or are redundant. For example, MBP cannot renew the license of a respiratory care practitioner, radiographer, naturopathic doctor, perfusionist, or PA for a term exceeding two years, while the term of a physician's license cannot exceed three years. Athletic trainers and polysomnographers do not have a license term limitation. In practice, the board renews all licenses for two-year terms. **Exhibit 4.1** lists the citation and the reason for each proposed change.

Recommendation 26: Statute should be amended to make nonsubstantive corrections and codify existing board practices.

Exhibit 4.1
Proposed Nonsubstantive Statutory Changes

Citation	Proposed Change	Reason for Change
§§ 14-101, 14-205, 14-412, 14-501, 14-502, 14-506, and in other articles of Maryland Code	Change terminology referencing the Maryland State Medical Society from "the Faculty" to "MedChi" and remove obsolete references to MedChi.	Outdated terminology and obsolete references.

Citation	Proposed Change	Reason for Change
§ 14-205	Repeal the redundant provision requiring the board to submit an annual report to the Faculty and to the Secretary of Health.	Redundant to another provision of Code.
§§ 14-316, 14-5A-13, 14-5B-12, 14-5C-14, 14-5D-12, 14-5E-13, 14-5F-15, and 15-307	Establish consistent license terms not exceeding three years for physicians and all allied health professions.	Inconsistent language; codifies existing practice.
§ 14-409	Clarify terminology to reflect that a license that has been suspended has the suspension terminated whereas "license reinstatement" applies to an expired, a revoked, or a surrendered license.	Codifies existing practice.
§§ 14-205, 14-402, 14-5A-22.1, 14-5B-18.1, 14-5B-19, 14-5C-22.1, 14-5C-23, and 15-403	Add or substitute references to "disciplinary panel" to reflect the two-panel disciplinary system.	Codifies existing practice.
§§ 14-316, 14-5A-13, 14-5B-12, 14-5C-14, 14-5D-12, 14-5E-13, 14-5F-15, and 15-307	Delete "annual" with regard to criminal history records checks at license renewal.	All licenses are renewed biennially.
§§ 14-302 and 14-602	Replace language referencing postgraduate medical programs "approved by the board" with "accredited by an accrediting organization recognized by the board."	Consistency with allied health provisions; codifies existing board practice.
§§ 14-312 and 14-321	Delete language relating to the restricted license to practice osteopathy.	Obsolete.
§ 14-5F-18	Correct reference that a disciplinary panel may discipline naturopathic doctor applicants or licensees for a violation of any provision of Title 14, rather than the Maryland Naturopathic Medicine Act.	Typographical error.
§ 14-407	Delete requirement that a licensee physically surrender a license on suspension or revocation and the board's requirement to return the license.	Obsolete; licenses are not issued by the board in physical form.
§ 14-401.1	Delete language relating to corrective action as a disciplinary action for failure to keep adequate medical records.	Obsolete.

Citation	Proposed Change	Reason for Change
§§ 14-5D-15 and 15-315	Delete redundant language requiring notice of an Office of Administrative Hearings hearing.	Redundant.
§ 15-203	Delete language authorizing the Governor to remove members of the Physician Assistant Advisory Committee.	Governor does not appoint these members, and this is the only advisory committee with this removal provision.
§§ 14-5B-01 and 14-5B-04	Delete reference to holders of temporary licenses for radiation technologists.	Obsolete.
§§ 14-5A-23, 14-5B-19, 14-5C-23, 14-5D-18, 14-5E-23, and 14-5F-29	Provide specific statutory citations for which penalties are applicable.	Clarifying; overbroad language could apply to other requirements established under the subtitle (*i.e.,* the requirement to update the licensee's name or address).
Subtitle 5B Title	Change to "Radiation Therapy, Radiography, Nuclear Medicine Technology, and Radiology Assistance."	Chapter 328 of 2008 altered the name of the associated advisory committee and the short title of the subtitle but did not change the title of the subtitle.

Source: Department of Legislative Services

Chapter 5. Survey Results

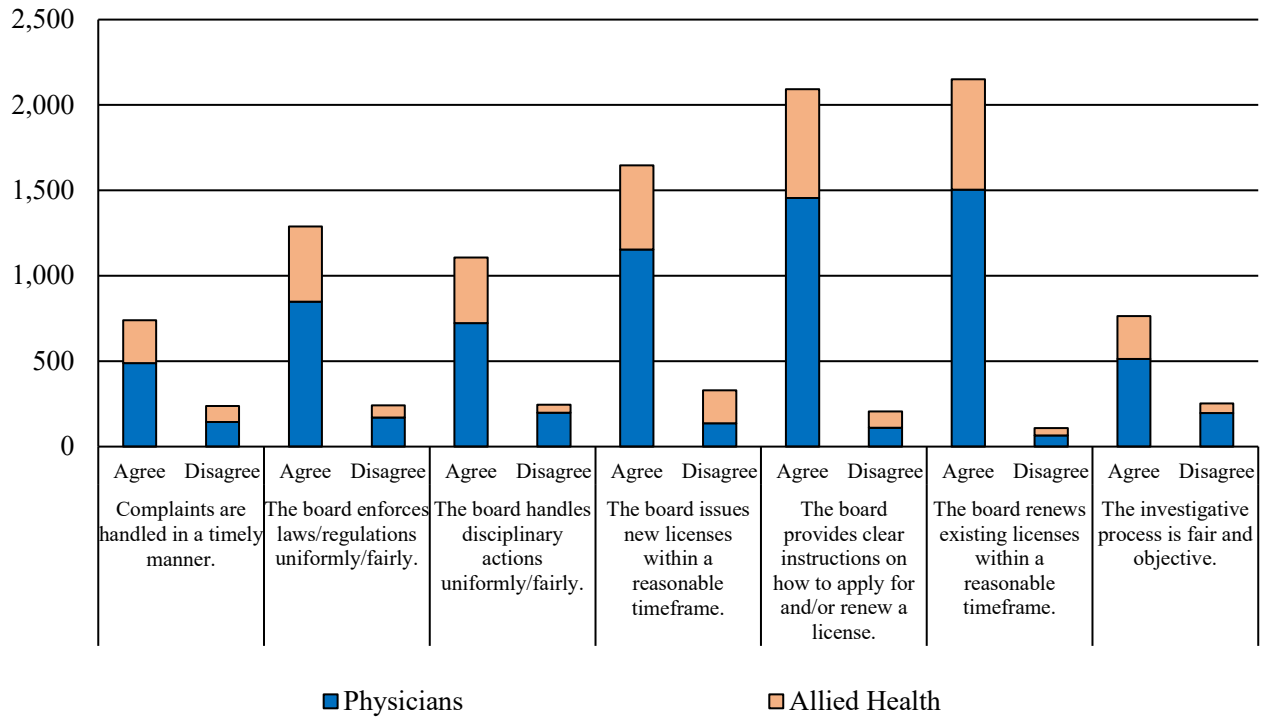
As part of this evaluation of the State Board of Physicians (MBP), the Department of Legislative Services (DLS) conducted a survey of individuals who are licensed by the board, including allied health professionals, to provide insight into their experiences with MBP. The survey was conducted via SurveyMonkey, with a link sent via email from MBP to current licensees with email addresses on file with the board. A link to the survey was also displayed on the home page of MBP's website. DLS contacted professional associations that represent individuals licensed by MBP to encourage their members to participate in the survey.

In total, the survey was sent to 44,259 individuals licensed by MBP. The survey had a response rate of 7.6% (3,356 total respondents) and, among those respondents, 73% completed the survey. The majority of respondents who completed the survey identified as physicians (1,695), with 754 respondents identifying as an allied health professional. The survey predominately consisted of multiple choice questions and asked respondents to consider interactions with the board and its staff and their performance over the past three years. A summary of the results of the full survey can be found in Appendix 5.

One portion of the survey focused on board processes – receiving and investigating complaints, enforcing regulations, and issuing new and renewal licensees. As shown in **Exhibit 5.1**, MBP is largely viewed positively in these measurements with more respondents agreeing with all statements. There is some variation in the rate of affirmative responses, particularly regarding the board's handling of complaints and investigations, which is in part due to many respondents not having experienced the board in its quasi-judicial capacity.

The largest number of affirmative responses related to the board's issuance of new and renewal licenses. Not only did respondents find the process to be clearly explained by the board, but they also felt that they were issued and renewed in a timely manner. This finding with the licensee survey is consistent with the Managing for Results data reported in the Governor's Budget Books and discussed in greater detail in Chapter 2.

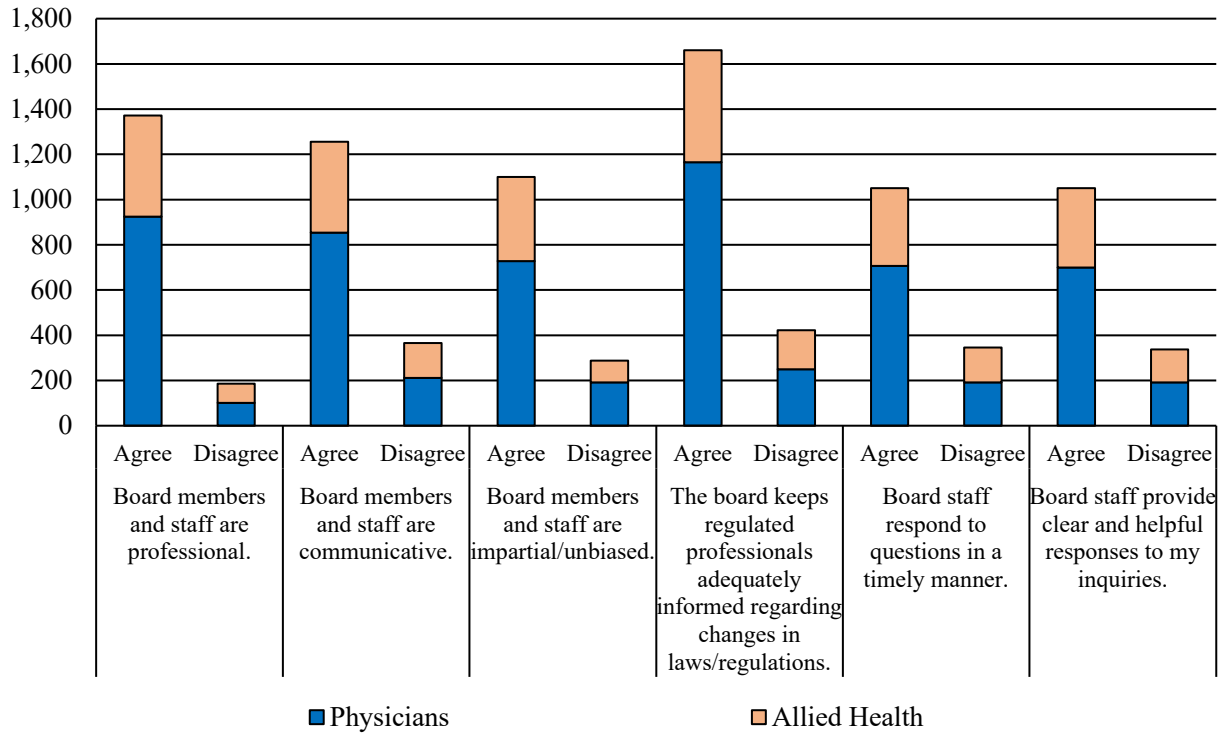
Exhibit 5.1
Board of Physicians Process Responses



Source: Department of Legislative Services

A separate set of questions related to interacting with members of the board and board staff. As shown in **Exhibit 5.2**, overall, respondents found board members and staff to be professional, communicative, unbiased, and helpful. The survey specifically asked respondents to consider their most recent interactions with board staff or any interaction within the past three years. Though responses varied somewhat, the board received the highest marks on keeping licensees well informed about changes in laws and regulations.

Exhibit 5.2
Board Members and Staff Survey Results



Source: Department of Legislative Services

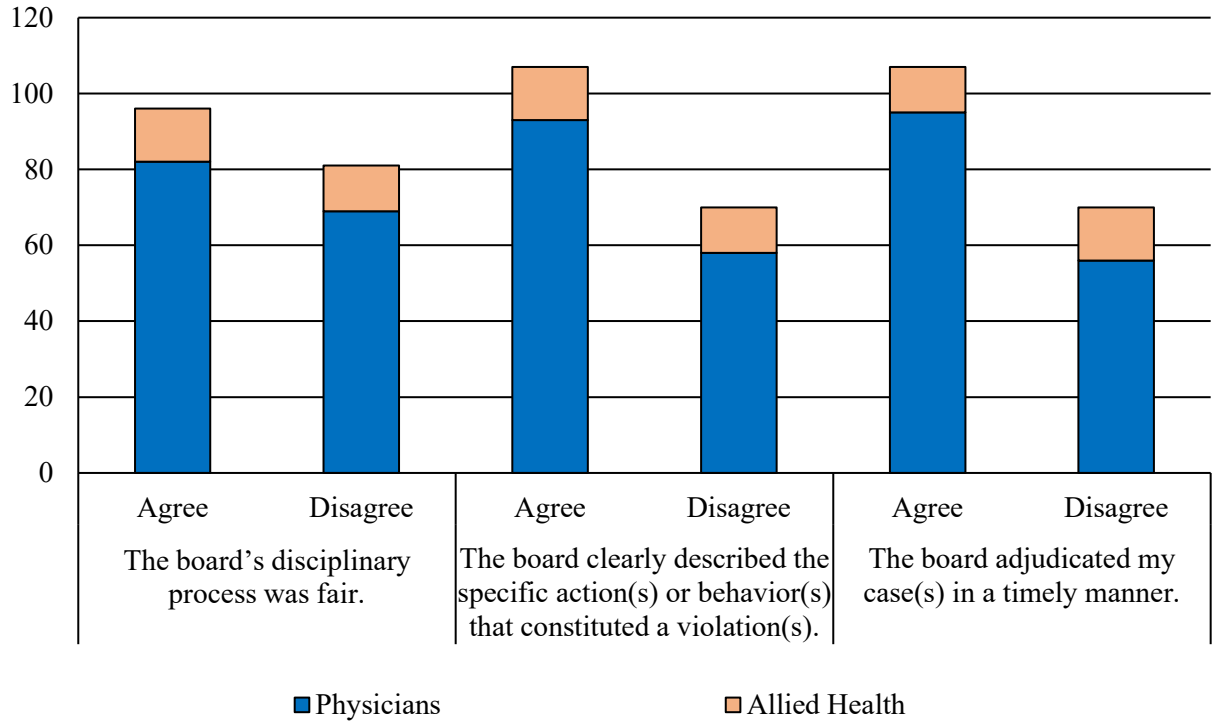
Even though the overall responses generally agreed that interactions with staff were professional, a number of comments provided to DLS through the survey (49 in total of 204 comments evaluated) identified negative interactions with board staff. The most frequent comment received as it related to board staff identified instances of poor communication between board staff and licensees. Specifically, many comments relayed difficulties reaching board staff over the phone with questions or concerns in the licensees' more recent interactions. Further, these commenters characterized the staff members themselves as having been rude or unhelpful when reached.

MBP advises that board staff use a telephone script and participate in customer service training including phone etiquette, the principles of which are frequently reinforced at staff meetings and staff retreats. The board also takes ongoing actions to improve customer interactions, such as adding information to the board's website.

Recommendation 27: The board should continue to improve communication with licensees and the public through training and policies to ensure phone and email inquiries receive prompt responses.

Only licensees who self-identified as having been disciplined by MBP were asked questions concerning the board's quasi-judicial function (a total of 177 respondents). This subset of respondents had generally positive feelings about the board's fairness, clarity, and timeliness. However, as shown in **Exhibit 5.3**, individuals who had been disciplined by the board expressed more negative opinions on the board's quasi-judicial function than seen in the other aspects of the board's operations.

Exhibit 5.3
Survey of Quasi-judicial Function



Source: Department of Legislative Services

Another frequent concern mentioned by survey respondents is that the board often investigates frivolous or unfounded complaints. However, DLS found that most complaints are dismissed outright or with an advisory letter. The share of licensees who have complaints lodged against them and are ultimately formally disciplined by the board is discussed in greater length in Chapter 3, but DLS' analysis has not found a pattern of the board disciplining licensees for unfounded complaints.

Chapter 6. Conclusion

The State Board of Physicians (MBP) and its related allied health advisory committees have continued to progress since the last Department of Legislative Services (DLS) sunset evaluation in 2016. The board functions well and meets its statutory missions. In addition, MBP has implemented the recommendations included in the 2016 evaluation or otherwise addressed the issues raised at that time.

The purpose of this report and its recommendations is to help MBP and its committees enhance their ability to protect the public health and welfare. DLS found that MBP's statutory authority could be clarified or enhanced, particularly related to the ability to take disciplinary action. Likewise, board processes could be refined, and MBP's responsiveness to licensees could be improved. Accordingly, recommendations made by DLS generally provide clarity to existing statute, increase uniformity in processes among the health occupations regulated by MBP, enhance board effectiveness, and remove outdated requirements and references. DLS recommendations were informed by discussions with board members, board staff, and stakeholder groups, as well as the licensee survey.

MBP and its committees are supported by dedicated board and allied health advisory committee members and staff. MBP plays a key role in protecting the public health and welfare, and there is no question that the board and its allied health advisory committees should continue to exist. Absent action during the 2020 legislative session, MBP and associated statutes (except for physician assistants) will terminate June 1, 2020. Based on these findings, DLS recommends that the termination dates of MBP and its allied health advisory committees be extended for 10 years and one month.

Recommendation 28: Statute should be amended to extend the termination date for the State Board of Physicians and its related allied health advisory committees to July 1, 2030.

Appendix 1. Draft Legislation

Bill No.: _____
Requested: _____
Committee: _____

Drafted by: Rowe
Typed by: Elise
Stored – 12/27/19
Proofread by _____
Checked by _____

By: **Leave Blank**

A BILL ENTITLED

AN ACT concerning

State Board of Physicians and Allied Health Advisory Committees – Sunset Extension and Program Evaluation

FOR the purpose of continuing the State Board of Physicians and the related allied health advisory committees by extending to a certain date the termination provisions relating to statutory and regulatory authority of the State Board of Physicians and the committees; altering the reasons for which a disciplinary panel of the Board is authorized to deny a certain license or refuse to renew or reinstate an applicant's license; altering the data that is required to be included in a certain annual report by the Board to include certain information regarding standard of care complaints and peer review; authorizing a disciplinary panel to issue a cease and desist order or obtain injunctive relief against an individual for certain misrepresentation; repealing the requirement that the Board chair and executive director be bonded; altering the circumstances under which a medical student or an individual in a postgraduate medical training program may practice medicine in the State without a license; altering the circumstances under which a physician may practice medicine at a hospital in the State without a license; altering the circumstances under which a physician in a neighboring state may practice medicine in the State without a license; requiring certain license applicants to complete, rather than submit to, a criminal history records check; prohibiting a disciplinary panel from reinstating a certain license unless the licensee completes, rather than submits to, a criminal history records check; establishing a certain maximum license term for all physicians

and allied health licensees; altering the circumstances under which certain licenses may be renewed or reinstated; altering the actions a disciplinary panel may take after being assigned certain complaints; authorizing a disciplinary panel to direct certain licensed physicians and allied health professionals to submit to a certain examination; authorizing a disciplinary panel to impose a fine on a licensee in addition to imposing certain sanctions under certain circumstances; requiring the Board to pay certain fines into the General Fund of the State; authorizing a disciplinary panel to require a licensee to comply with certain terms and conditions under certain circumstances; repealing the authority of a disciplinary panel under certain circumstances to impose a fine instead of suspending a license; altering the medical malpractice information that is required to be posted to a licensee's public profile; exempting, under certain circumstances, an individual licensed by and residing in another jurisdiction to practice respiratory care in the State from a certain licensure requirement; authorizing a disciplinary panel, rather than the Board, to impose a certain civil penalty for a violation of certain provisions of law; clarifying that certain penalties apply to violations of certain provisions of law; altering the memberships of the Radiation Therapy, Radiography, Nuclear Medicine Technology, and Radiology Assistance Advisory Committee, the Athletic Trainer Advisory Committee, the Naturopathic Doctors Formulary Council, and the Naturopathic Medicine Advisory Committee; altering the circumstances under which the Board is required to reinstate certain licenses; altering the grounds for which a disciplinary panel may take certain actions against certain applicants and licensees; requiring an athletic trainer to submit a copy of the evaluation and treatment protocol for Board approval, rather than obtaining Board approval of the evaluation and treatment protocol, before being authorized to practice athletic training; altering the circumstances under which a certain supervising physician may assume a certain role; authorizing the Board to terminate the evaluation and treatment protocol of an athletic trainer or delegation agreement of a physician assistant under certain circumstances; altering the time at which an athletic trainer or a physician assistant is authorized to assume certain duties under certain circumstances; requiring a supervising physician or an employer to notify the Board within a certain time period of the termination of a physician assistant for certain reasons; requiring a physician assistant and supervising physician to notify the Board of the termination of the relationship under a delegation agreement for any reason; authorizing a physician assistant to terminate a delegation agreement at any time subject to certain notice requirements; altering the time period that certain health occupations boards must provide certain licensees and certificate holders to provide the board with a certain response; altering a certain defined term; requiring

the Board to include certain information and make certain recommendations in certain reports; repealing obsolete and redundant language; clarifying and reorganizing certain provisions of law; making conforming changes; making this Act an emergency measure; and generally relating to the State Board of Physicians and the related allied health advisory committees.

BY repealing and reenacting, with amendments,
Article – Courts and Judicial Proceedings
Section 5–715(a) and (b)
Annotated Code of Maryland
(2013 Replacement Volume and 2019 Supplement)

BY repealing and reenacting, with amendments,
Article – Health – General
Section 13–1201 and 13–1204(a) and (b)
Annotated Code of Maryland
(2019 Replacement Volume)

BY repealing and reenacting, with amendments,
Article – Health Occupations
Section 1–401(b)(2) and (9), 1–604, 14–101(g) through (j), 14–205(a)(20), (b)(3), and (c)(1), 14–205.1(1), 14–206(e), 14–302, 14–307(i), 14–309(a)(1), 14–312.1, 14–316(a), (c), and (g)(1)(i), 14–317, 14–401.1(c)(1), 14–402(a) and (c), 14–404(a)(42) through (45), 14–407, 14–409, 14–411.1(b), 14–412, 14–501(c), 14–502(b)(1), (2), and (3), 14–506(b)(1), 14–5A–08, 14–5A–09(e), 14–5A–10(1), 14–5A–13(a), (c), and (g)(1), 14–5A–17(a)(28), 14–5A–19(c)(2), 14–5A–22.1(c), 14–5A–23(a) and (b), 14–5A–25; 14–5B–01(q), 14–5B–04(a), 14–5B–05(b), 14–5B–09(b)(5), 14–5B–10(a)(1), 14–5B–12(a), (c), (f), and (g) and (1)(i), 14–5B–14(a)(28), 14–5B–16(c)(2), 14–5B–18.1(c), 14–5B–19(a) and (b), 14–5B–21 to be under amended the subtitle "Subtitle 5B. Radiation Therapy, Radiography, Nuclear Medicine Technology, and Radiology Assistance"; 14–5C–09(b)(3), 14–5C–11(1), 14–5C–14(a), (c), and (g)(1), 14–5C–17(a)(26) through (29), 14–5C–19(c)(2), 14–5C–22.1(c), 14–5C–23(a) and (b), 14–5C–25, 14–5D–05(a), 14–5D–08(b)(3), 14–5D–09(a)(1), 14–5D–11(b) and (e), 14–5D–11.3, 14–5D–12(a), (c), and (h)(1), 14–5D–14(a)(29), 14–5D–15, 14–5D–16(c)(2), 14–5D–18(a) and (b), 14–5D–20, 14–5E–09(b)(3), 14–5E–11(a)(1), 14–5E–13(a), (c)(1), and (g)(1), 14–5E–16(a)(26) through (29), 14–5E–19(c)(2), 14–5E–23(a) and (b), 14–5E–25, 14–5F–04.1(a)(2)(ii)2.,

14–5F–07(a)(1) and (c), 14–5F–11(g), 14–5F–12(1), 14–5F–15(a), (c), and (d)(1)(i), 14–5F–18(a)(27), 14–5F–22, 14–5F–24(c), 14–5F–29, 14–5F–32, 14–602(b)(5), 14–702, 15–103(b), 15–202(a)(3), 15–203, 15–302, 15–302.1, 15–303(a)(1), 15–304(1), 15–307(a) and (g)(1), 15–308(b), 15–311, 15–314(a)(42) and (43), 15–315(a), 15–316(a), 15–403(b), and 15–502
Annotated Code of Maryland
(2014 Replacement Volume and 2019 Supplement)

BY repealing and reenacting, without amendments,
Article – Health Occupations
Section 14–101(a), 14–201, 14–404(a)(40) and (43), 14–5B–01(a), and 15–202(a)(1) and (2)
Annotated Code of Maryland
(2014 Replacement Volume and 2019 Supplement)

BY repealing
Article – Health Occupations
Section 14–101(f), 14–208, 14–302.1, 14–312, 14–321, 14–401.1(c)(4), 14–405.1, 14–5C–17(a)(25), and 14–5E–16(a)(25)
Annotated Code of Maryland
(2014 Replacement Volume and 2019 Supplement)

BY adding to
Article – Health Occupations
Section 14–101(j), 14–404(a)(46), (d), and (e), 14–5A–17(d) and (e), 14–5B–14(d) and (e), 14–5C–17(d) and (e), 14–5D–14(d) and (e), 14–5E–16(d) and (e), 14–5F–18(d) and (e), 15–314(a)(44) and (45), and 15–316(c)
Annotated Code of Maryland
(2014 Replacement Volume and 2019 Supplement)

BY repealing and reenacting, with amendments,
Article – Health Occupations
Section 14–404(a)(43)
Annotated Code of Maryland
(2014 Replacement Volume and 2019 Supplement)
(As enacted by Chapter 470 of the Acts of the General Assembly of 2018)

BY adding to

Article – Health Occupations
Section 14–404(a)(44)
Annotated Code of Maryland
(2014 Replacement Volume and 2019 Supplement)
(As enacted by Chapter 470 of the Acts of the General Assembly of 2018)

BY repealing and reenacting, with amendments,
Article – Health Occupations
Section 14–404(a)(44)
Annotated Code of Maryland
(2014 Replacement Volume and 2019 Supplement)
(As enacted by Section 1 of this Act)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Courts and Judicial Proceedings

5–715.

(a) **[**(1)**]** In this section **[**the following words have the meanings indicated.

(2)**],** "Board" means the State Board of Physicians.

[(3) "Faculty" means the Medical and Chirurgical Faculty of the State of Maryland.**]**

(b) A person who acts without malice and is a member of the Board or a legally authorized agent of the Board, is not civilly liable for investigating, prosecuting, participating in a hearing under § 14–405 of the Health Occupations Article, or otherwise acting on an allegation of a ground for Board action made to the Board **[**or the Faculty**]**.

Article – Health – General

13–1201.

(a) In this subtitle the following words have the meanings indicated.

(b) "Data use agreement" means an agreement between the Department and a national, State, or local agency or program that establishes the terms and conditions for the confidential submission, collection, storage, analysis, reporting, aggregation, and dissemination of de–identified data obtained from the Maternal Mortality Review Program.

(c) **[**"Faculty" means the Medical and Chirurgical Faculty in the State.

(d)**]** "Local team" means the multidisciplinary and multiagency maternal mortality review team established for a county.

[(e)**] (D)** "Maternal mortality review committee" means the maternal mortality review committee of **[**the Faculty**] MEDCHI** that is a medical review committee, as defined under § 1–401 of the Health Occupations Article.

[(f)**] (E)** "Maternal death" means the death of a woman during pregnancy or within 1 year after the woman ceases to be pregnant.

(F) "MEDCHI" MEANS THE MARYLAND STATE MEDICAL SOCIETY.

13–1204.

(a) The Secretary may contract with **[**the Faculty**] MEDCHI** to administer the Maternal Mortality Review Program.

(b) In consultation with the maternal mortality review committee of **[**a faculty**] MEDCHI**, the Secretary shall develop a system to:

(1) Identify maternal death cases;

(2) Review medical records and other relevant data;

(3) Contact family members and other affected or involved persons to collect additional relevant data;

(4) Consult with relevant experts to evaluate the records and data collected;

(5) Make determinations regarding the preventability of maternal deaths;

(6) Develop recommendations for the prevention of maternal deaths; and

(7) Disseminate findings and recommendations to policy makers, health care providers, health care facilities, and the general public.

Article – Health Occupations

1–401.

(b) For purposes of this section, a medical review committee is:

(2) A committee of the **[**Faculty**]** **MARYLAND STATE MEDICAL SOCIETY** or any of its component societies or a committee of any other professional society or association composed of providers of health care;

(9) An organization, established by the Maryland Hospital Association, Inc. and the **[**Faculty**]** **MARYLAND STATE MEDICAL SOCIETY**, that contracts with a hospital, related institution, or alternative delivery system to:

(i) Assist in performing the functions listed in subsection (c) of this section; or

(ii) Assist a hospital in meeting the requirements of § 19–319(e) of the Health – General Article;

1–604.

(a) If a statute authorizes a health occupations board to use a system of peer review in standard of care cases and the peer reviewer or peer reviewers determine that there has been a violation of a standard of care, the board shall provide the licensee or certificate holder under investigation **[**with an**]:**

(1) AN opportunity to review the final peer review report**;** and

(2) AT LEAST 10 BUSINESS DAYS AFTER THE REPORT WAS SENT TO THE LICENSEE OR CERTIFICATE HOLDER TO provide the board with a written response **[**within 10 business days after the report was sent to the licensee or certificate holder**]**.

(b) If a health occupations board receives a written response to a final peer review report, the board shall consider both the report and response before taking any action.

14–101.

(a) In this title the following words have the meanings indicated.

[(f) "Faculty" means the Medical and Chirurgical Faculty of the State of Maryland.**]**

[(g)**] (F)** "Hospital" has the meaning stated in § 19–301 of the Health – General Article.

[(h)**] (G)** "License" means, unless the context requires otherwise, a license issued by the Board to practice medicine.

[(i)**] (H)** "Licensed physician" means, unless the context requires otherwise, a physician, including a doctor of osteopathy, who is licensed by the Board to practice medicine.

[(j)**] (I)** "Licensee" means an individual to whom a license is issued, including an individual practicing medicine within or as a professional corporation or professional association.

(J) "MEDCHI" MEANS THE MARYLAND STATE MEDICAL SOCIETY.

14–201.

There is a State Board of Physicians in the Department.

14–205.

(a) In addition to the powers and duties set forth in this title and in Title 15 of this article, the Board shall:

(20) Delegate to the executive director of the Board the authority to discharge Board **OR DISCIPLINARY PANEL** duties, as deemed appropriate and necessary

by the Board **OR DISCIPLINARY PANEL**, and hold the executive director accountable to the Board; and

(b) (3) Subject to the Administrative Procedure Act and the hearing provisions of § 14–405 of this title, a disciplinary panel may deny a license to an applicant or, if an applicant has failed to renew the applicant's license, refuse to renew or reinstate an applicant's license for:

(i) Any of the reasons that are grounds for action under § 14–404**, § 14–5A–17, § 14–5B–14, § 14–5C–17, § 14–5D–14, § 14–5E–16, OR § 14–5F–18** of this title**, AS APPLICABLE**; or

(ii) Failure to **[**submit to**]** **COMPLETE** a criminal history records check in accordance with § 14–308.1 of this title.

(c) (1) In addition to the duties set forth elsewhere in this title, the Board shall:

(i) **[**Submit an annual report to the Faculty and to the Secretary;

(ii)**]** Issue, for use in other jurisdictions, a certificate of professional standing to any licensed physician; and

[(iii)**] (II)** Keep a list of all license applicants.

14–205.1.

On or before October 1 each year, the Board shall submit to the Governor, the Secretary, and, in accordance with § 2–1257 of the State Government Article, the General Assembly an annual report that includes the following data calculated on a fiscal year basis:

(1) Relevant disciplinary indicators, including:

(i) The number of physicians investigated under each of the disciplinary grounds enumerated under § 14–404 of this **[**article**]** **TITLE**;

(ii) The number of physicians who were reprimanded or placed on probation or who had their licenses suspended or revoked;

(iii) The number of cases prosecuted and dismissed and on what grounds;

(iv) The criteria used to accept and reject cases for prosecution; **[**and**]**

(v) The number of unresolved allegations pending before the Board; **AND**

(VI) WITH REGARD TO STANDARD OF CARE COMPLAINTS:

1. THE TOTAL NUMBER OF COMPLAINTS FILED;

2. THE TOTAL NUMBER OF COMPLAINTS FILED THAT WERE CLOSED OUTRIGHT OR WITH AN ADVISORY LETTER;

3. THE TOTAL NUMBER OF COMPLAINTS FILED THAT WERE SENT TO PEER REVIEW; AND

4. OF THE COMPLAINTS SENT TO PEER REVIEW, HOW OFTEN THE PEER REVIEWERS DISAGREED WHOLLY OR IN PART;

14–206.

(e) A disciplinary panel may issue a cease and desist order or obtain injunctive relief against an individual for:

(1) Practicing medicine without a license; **[**or**]**

(2) REPRESENTING TO THE PUBLIC, BY DESCRIPTION OF SERVICES, METHODS, PROCEDURES, OR OTHERWISE, THAT THE INDIVIDUAL IS AUTHORIZED TO PRACTICE MEDICINE IN THIS STATE, IN VIOLATION OF § 14–602 OF THIS TITLE; OR

[(2)**] (3)** Taking any action:

(i) For which a disciplinary panel determines there is a preponderance of evidence of grounds for discipline under § 14–404 of this title; and

(ii) That poses a serious risk to the health, safety, and welfare of a patient.

[14–208.

The executive director and the Board chair shall be bonded in an amount fixed by the Board.**]**

14–302.

[(a)**]** Subject to the rules, regulations, and orders of the Board, the following individuals may practice medicine without a license:

(1) A medical student or an individual in a postgraduate medical training program that is **[**approved**]** **ACCREDITED BY AN ACCREDITING ORGANIZATION RECOGNIZED** by the Board **IN REGULATIONS**, while **THE INDIVIDUAL IS PRACTICING MEDICINE IN THE PROGRAM AND** doing the assigned duties at any office of a licensed physician, hospital, clinic, or similar facility;

(2) A physician licensed by and residing in another jurisdiction, if the physician:

(i) Is engaged in consultation with a physician licensed in the State about a particular patient and does not direct patient care; **[**or**]**

[(ii) Meets the requirements of § 14–302.1 of this subtitle;**]**

(II) 1. HAS AN ACTIVE, UNRESTRICTED LICENSE TO PRACTICE MEDICINE IN THE JURISDICTION WHERE THE PHYSICIAN REGULARLY ENGAGES IN THE PRACTICE OF MEDICINE;

2. IS EMPLOYED BY OR HAS A WRITTEN AGREEMENT WITH AN ATHLETIC TEAM OR A SPORTS TEAM BASED OUTSIDE THE STATE;

3. IS DESIGNATED AS THE TEAM PHYSICIAN BY THE ATHLETIC OR SPORTS TEAM TO PROVIDE MEDICAL CARE TO THE TEAM'S MEMBERS, BAND MEMBERS, CHEERLEADING SQUAD, MASCOT, COACHES, AND OTHER STAFF WHO TRAVEL TO A SPECIFIED SPORTING EVENT TAKING PLACE IN THE STATE;

4. WHILE IN THE STATE, PROVIDES MEDICAL CARE ONLY TO INDIVIDUALS LISTED IN ITEM 3 OF THIS ITEM;

5. DOES NOT PROVIDE MEDICAL CARE IN THE STATE FOR MORE THAN 45 DAYS IN A CALENDAR YEAR; AND

6. DOES NOT ENGAGE IN THE PRACTICE OF MEDICINE AT A HOSPITAL, RELATED INSTITUTION, OR OTHER HEALTH CARE FACILITY, INCLUDING AN ACUTE CARE FACILITY, LOCATED WITHIN THE STATE; OR

(III) IS ENGAGED IN CLINICAL TRAINING OR PARTICIPATES IN TRAINING OR TEACHING OF A SKILL OR PROCEDURE IN A HOSPITAL IF:

1. THE SKILL OR PROCEDURE:

A. IS ADVANCED BEYOND THOSE SKILLS OR PROCEDURES NORMALLY TAUGHT OR EXERCISED IN THE HOSPITAL AND IN STANDARD MEDICAL EDUCATION OR TRAINING;

B. COULD NOT BE OTHERWISE CONVENIENTLY TAUGHT OR DEMONSTRATED IN STANDARD MEDICAL EDUCATION OR TRAINING IN THAT HOSPITAL; AND

C. IS LIKELY TO BENEFIT MARYLAND PATIENTS IN THIS INSTANCE;

2. THE DEMONSTRATION OF THE SKILL OR PROCEDURE WOULD TAKE NOT MORE THAN 14 CONSECUTIVE DAYS WITHIN A CALENDAR YEAR;

3. A LICENSED PHYSICIAN WHO PRACTICES AT A HOSPITAL IN THE STATE WILL BE RESPONSIBLE FOR THE MEDICAL CARE PROVIDED BY THAT VISITING PHYSICIAN TO PATIENTS IN THE STATE;

4. THE VISITING PHYSICIAN HAS NO HISTORY OF ANY MEDICAL DISCIPLINARY ACTION IN ANY OTHER STATE, TERRITORY, NATION, OR ANY BRANCH OF THE UNITED STATES UNIFORMED SERVICES OR THE VETERANS ADMINISTRATION, AND HAS NO SIGNIFICANT DETRIMENTAL MALPRACTICE

HISTORY;

5. THE PHYSICIAN IS COVERED BY MALPRACTICE INSURANCE IN THE JURISDICTION IN WHICH THE PHYSICIAN PRACTICES; AND

6. THE HOSPITAL ENSURES THAT THE PATIENTS WILL BE PROTECTED BY ADEQUATE MALPRACTICE INSURANCE;

(3) A physician employed in the service of the federal government while performing the duties incident to that employment;

(4) A physician who resides in and is authorized to practice medicine by any state adjoining this State **[**and whose practice extends into this State**]** **FOR THE PURPOSE OF PRESCRIBING HOME HEALTH SERVICES TO A PATIENT WHO RESIDES IN THIS STATE**, if **THE PHYSICIAN**:

(i) **[**The physician does**]** **DOES** not have an office or other regularly appointed place in this State to meet patients; and

(ii) **[**The same privileges are extended to licensed physicians of this State by the adjoining state**]** **HAS PERFORMED AN IN–PERSON PHYSICAL EXAMINATION OF THE PATIENT WITHIN THE JURISDICTIONAL BOUNDARIES OF THE ADJOINING STATE IN WHICH THE PRESCRIBING PHYSICIAN IS AUTHORIZED TO PRACTICE MEDICINE**; and

(5) An individual while under the supervision of a licensed physician who has specialty training in psychiatry, and whose specialty training in psychiatry has been approved by the Board, if the individual submits an application to the Board on or before October 1, 1993, and either:

(i) 1. Has a master's degree from an accredited college or university; and

2. Has completed a graduate program accepted by the Board in a behavioral science that includes 1,000 hours of supervised clinical psychotherapy experience; or

(ii) 1. Has a baccalaureate degree from an accredited college or

university; and

2. Has 4,000 hours of supervised clinical experience that is approved by the Board.

[(b) A physician licensed by and residing in another jurisdiction may practice medicine without a license and without submitting to a criminal history records check if the physician:

(1) Has an active, unrestricted license to practice medicine in the jurisdiction where the physician regularly engages in the practice of medicine;

(2) Is employed by or has a written agreement with an athletic team or a sports team based outside the State;

(3) Is designated as the team physician by the athletic or sports team to provide medical care to the team's members, band members, cheerleading squad, mascot, coaches, and other staff who travel to a specified sporting event taking place in the State;

(4) While in the State, provides medical care only to individuals listed in item (3) of this subsection;

(5) Does not provide medical care in the State for more than 45 days in a calendar year; and

(6) Does not engage in the practice of medicine at a hospital, related institution, or other health care facility, including an acute care facility, located within the State.**]**

[14–302.1.

A physician who is licensed and resides in another jurisdiction may practice medicine without a license while engaged in clinical training with a licensed physician if:

(1) The Board finds, on application by a hospital in the State, that:

(i) The physician possesses a skill or uses a procedure that:

1. Is advanced beyond those skills or procedures normally taught or exercised in the hospital and in standard medical education or training;

2. Could not be otherwise conveniently taught or demonstrated in standard medical education or training in that hospital; and

3. Is likely to benefit Maryland patients in this instance;

(ii) The demonstration of the skill or procedure would take no more than 14 consecutive days within a calendar year;

(iii) A licensed physician who practices at a hospital in the State has certified to the Board that the licensed physician will be responsible for the medical care provided by that visiting physician to patients in the State;

(iv) The visiting physician has no history of any medical disciplinary action in any other state, territory, nation, or any branch of the United States uniformed services or the Veterans Administration, and has no significant detrimental malpractice history in the judgment of the Board;

(v) The physician is covered by malpractice insurance in the jurisdiction in which the physician practices; and

(vi) The hospital assures the Board that the patients will be protected by adequate malpractice insurance; or

(2) The Board finds, on application by a Maryland hospital, that:

(i) The hospital provides training in a skill or uses a procedure that:

1. Is advanced beyond those skills or procedures normally taught or exercised in standard medical education or training;

2. Could not be otherwise conveniently taught or demonstrated in the visiting physician's practice; and

3. Is likely to benefit Maryland patients in this instance;

(ii) The demonstration or exercise of the skill or procedure will take no more than 14 consecutive days within a calendar year;

(iii) A hospital physician licensed in the State has certified to the Board that the physician will be responsible for the medical care provided by that visiting physician to patients in the State;

(iv) The visiting physician has no history of any medical disciplinary action in any other state, territory, nation, or any branch of the United States uniformed services or the Veterans Administration, and has no significant detrimental malpractice history in the judgment of the Board;

(v) The physician is covered by malpractice insurance in the jurisdiction where the physician practices; and

(vi) The hospital assures the Board that the patients will be protected by adequate malpractice insurance.**]**

14–307.

(i) The applicant shall **[**submit to**]** **COMPLETE** a criminal history records check in accordance with § 14–308.1 of this subtitle.

14–309.

(a) To apply for a license, an applicant shall:

(1) **[**Submit to**]** **COMPLETE** a criminal history records check in accordance with § 14–308.1 of this subtitle;

[14–312.

(a) In this section, "approved school of osteopathy" means a school of osteopathy that is approved by the American Osteopathic Association.

(b) Subject to the provisions of this section, the Board shall waive the examination requirements of this subtitle for an applicant who is licensed to practice osteopathy.

(c) If the applicant is licensed to practice osteopathy in this State under § 14–321 of this subtitle, the Board may grant a waiver under this section only if the applicant:

(1) Submits to a criminal history records check in accordance with § 14–308.1 of this subtitle;

(2) Submits the application fee required by the Board under § 14–309 of this subtitle; and

(3) Provides adequate evidence that the applicant:

(i) Meets the qualifications otherwise required by this title; and

(ii) 1. Practiced osteopathy and resided in this State on June 1, 1967;

2. Graduated in or after 1940 from an approved school of osteopathy; or

3. Graduated before 1940 from an approved school of osteopathy and completed a refresher education course approved by the Board.

(d) If the applicant is licensed as a doctor of osteopathy to practice medicine in another state, the Board may grant a waiver under this section only if the applicant:

(1) Submits to a criminal history records check in accordance with § 14–308.1 of this subtitle;

(2) Submits the application fee set by the Board under § 14–309 of this subtitle;

(3) Provides adequate evidence that the applicant:

(i) Meets the qualifications otherwise required by this title;

(ii) Graduated after January 1, 1960 from an approved school of osteopathy; and

(iii) Became licensed in the other state after passing in that state an examination for the practice of medicine given by the appropriate authority in the other state to graduates of approved medical schools; and

(4) Submits evidence that the other state waives the examination of licensees of this State to a similar extent as this State waives the examination of individuals licensed in that state.**]**

[14–312.1.**] 14–312.**

On request of the Board, a physician who reports to the Board that the physician maintains medical professional liability insurance for purposes of the public individual profile maintained by the Board under § 14–411.1(b) of this title shall provide the Board with verification or other documentation that the physician maintains the insurance within 25 business days after the physician receives a request from the Board.

14–316.

(a) (1) **[**The Board shall provide for the term and renewal of licenses under this section.

(2)**]** The term of a license **ISSUED BY THE BOARD** may not **[**be more than**]** **EXCEED** 3 years.

[(3)**] (2)** A license expires **[**at the end of its term**] ON A DATE SET BY THE BOARD**, unless the license is renewed for a term as provided **[**by the Board**] IN THIS SECTION**.

(c) (1) Before the license expires, the licensee periodically may renew it for an additional term, if the licensee:

(i) Otherwise is entitled to be licensed;

(II) IS OF GOOD MORAL CHARACTER;

[(ii)**] (III)** Pays to the Board a renewal fee set by the Board; and

[(iii)**] (IV)** Submits to the Board:

1. A renewal application on the form that the Board requires; and

2. Satisfactory evidence of compliance with any continuing education requirements set under this section for license renewal.

(2) Within 30 days after a license renewal under Section 7 of the Interstate Medical Licensure Compact established under § 14–3A–01 of this title, a compact physician shall submit to the Board the information required under paragraph **[**(1)(iii)**] (1)(IV)** of this subsection.

(g) (1) Beginning October 1, 2016, the Board shall require a criminal history records check in accordance with § 14–308.1 of this subtitle for:

(i) **[**Annual renewal**] RENEWAL** applicants as determined by regulations adopted by the Board; and

14–317.

The Board shall reinstate the license of a physician who has failed to renew the license for any reason if the physician:

(1) Meets the renewal requirements of § 14–316 of this subtitle;

(2) IS OF GOOD MORAL CHARACTER;

[(2)**] (3)** Pays to the Board a reinstatement fee set by the Board; and

[(3)**] (4)** Submits to the Board satisfactory evidence of compliance with the qualifications and requirements established under this title for license reinstatements.

[14–321.

(a) (1) In this section the following words have the meanings indicated.

(2) "Practice osteopathy" means to treat a disease or ailment of the human body by manipulation.

(3) "Restricted license" means a license issued by the Board to practice osteopathy.

(b) The Board shall issue a restricted license only to an applicant who:

(1) Was licensed to practice osteopathy in this State or in another state on June 30, 1980;

(2) Is licensed to practice osteopathy in this State or in another state on the date that the application for a restricted license is submitted to the Board;

(3) Submits an application to the Board on the form that the Board requires;

(4) Pays to the Board the restricted license fee set by the Board; and

(5) Meets any other requirement set by the Board.

(c) A restricted license authorizes the license holder to practice osteopathy while the restricted license is effective.

(d) The term and renewal of a restricted license shall be as provided for a license under § 14–316 of this subtitle.

(e) (1) Subject to the requirements of the Administrative Procedure Act, the Board on the affirmative vote of a majority of its quorum, may reprimand a restricted license holder, may place any restricted license holder on probation, or suspend or revoke a restricted license for any of the grounds for Board action under § 14–404 of this title.

(2) The Board may only dismiss a case against a restricted license holder on the affirmative vote of a majority of its quorum.**]**

14–401.1.

(c) (1) Except as otherwise provided in this subsection, after being assigned a complaint under subsection (a) of this section, the disciplinary panel may:

(i) Refer an allegation for further investigation to the entity that has contracted with the Board under subsection (e) of this section; **OR**

(ii) Take any appropriate and immediate action as necessary**[**; or

(iii) Come to an agreement for corrective action with a licensee pursuant to paragraph (4) of this subsection**]**.

[(4) (i) Except as provided in subparagraph (ii) of this paragraph, if an allegation is based on § 14–404(a)(40) of this subtitle, a disciplinary panel:

1. May determine that an agreement for corrective action is warranted; and

2. Shall notify the licensee of the identified deficiencies and enter into an agreement for corrective action with the licensee as provided in this paragraph.

(ii) A disciplinary panel may not enter into an agreement for corrective action with a licensee if patient safety is an issue.

(iii) The disciplinary panel shall subsequently evaluate the licensee and shall:

1. Terminate the corrective action if the disciplinary panel is satisfied that the licensee is in compliance with the agreement for corrective action and has corrected the deficiencies; or

2. Pursue disciplinary action under § 14–404 of this subtitle if the deficiencies persist or the licensee has failed to comply with the agreement for corrective action.

(iv) An agreement for corrective action under this paragraph may not be made public or considered a disciplinary action under this title.

(v) The Board shall provide a summary of each disciplinary panel's corrective action agreements in the executive director's report of Board activities.**]**

14–402.

(a) In reviewing an application for licensure**[**, certification, or registration**]** or in investigating an allegation brought against a licensed physician or any allied health professional regulated by the Board under this title, the Physician Rehabilitation Program may request the Board to direct, or the Board **OR A DISCIPLINARY PANEL** on its own initiative may direct, the licensed physician or any allied health professional regulated by the Board under this title to submit to an appropriate examination.

(c) The unreasonable failure or refusal of the licensed**[**, certified, or registered**]** individual to submit to an examination is prima facie evidence of the licensed**[**, certified, or registered**]** individual's inability to practice medicine or the respective discipline competently, unless the Board **OR DISCIPLINARY PANEL** finds that the failure or refusal was beyond the control of the licensed**[**, certified, or registered**]** individual.

14–404.

(a) Subject to the hearing provisions of § 14–405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

(40) Fails to keep adequate medical records as determined by appropriate peer review;

(42) Fails to **[**submit to**]** **COMPLETE** a criminal history records check under § 14–308.1 of this title;

(44) Fails to meet the qualifications for licensure under Subtitle 3 of this title; **[**or**]**

(45) Fails to comply with § 1–223 of this article**; OR**

(46) FAILS TO COMPLY WITH THE REQUIREMENTS OF THE PRESCRIPTION DRUG MONITORING PROGRAM UNDER TITLE 21, SUBTITLE 2A OF THIS ARTICLE.

(D) (1) IF, AFTER A HEARING UNDER § 14–405 OF THIS SUBTITLE, A

DISCIPLINARY PANEL FINDS THAT THERE ARE GROUNDS UNDER SUBSECTION (A) OF THIS SECTION TO SUSPEND OR REVOKE A LICENSE, TO REPRIMAND A LICENSEE, OR TO PLACE A LICENSEE ON PROBATION, THE DISCIPLINARY PANEL MAY IMPOSE A FINE SUBJECT TO THE BOARD'S REGULATIONS IN ADDITION TO SUSPENDING OR REVOKING THE LICENSE, REPRIMANDING THE LICENSEE, OR PLACING THE LICENSEE ON PROBATION.

(2) THE BOARD SHALL PAY ANY FINES COLLECTED UNDER THIS SECTION INTO THE GENERAL FUND OF THE STATE.

(E) IN ADDITION TO ANY SANCTION AUTHORIZED UNDER THIS SECTION, A DISCIPLINARY PANEL MAY REQUIRE A LICENSEE TO COMPLY WITH SPECIFIED TERMS AND CONDITIONS DETERMINED BY THE DISCIPLINARY PANEL.

[14–405.1.

(a) If after a hearing under § 14–405 of this subtitle a disciplinary panel finds that there are grounds under § 14–404 of this subtitle to suspend or revoke a license to practice medicine or osteopathy, or to reprimand a licensed physician or osteopath, the disciplinary panel may impose a fine subject to the Board's regulations:

(1) Instead of suspending the license; or

(2) In addition to suspending or revoking the license or reprimanding the licensee.

(b) The Board shall pay any fines collected under this section into the General Fund.**]**

14–407.

(a) An order of suspension or revocation is effective, in accordance with its terms and conditions, as soon as a disciplinary panel files it under this title.

(b) **[**On suspension or revocation of any license, the holder shall surrender the license certificate to the Board.

(c) At the end of the suspension period, the Board shall return to the licensee any

license certificate surrendered under this section.

(d)**]** The Board shall keep a copy of the order of suspension or revocation as a permanent record.

14–409.

(a) (1) Except as provided in subsection (b) of this section, a disciplinary panel may reinstate the license of an individual whose license has been **[**suspended**]** **SURRENDERED** or revoked under this title only in accordance with:

(i) The terms and conditions of the order of **[**suspension or**]** revocation **OR LETTER OF SURRENDER**;

(ii) An order of reinstatement issued by the disciplinary panel; or

(iii) A final judgment in any proceeding for review.

(2) If a disciplinary panel reinstates a license under paragraph (1) of this subsection, the disciplinary panel shall notify the Board of the reinstatement.

(3) If a license is **[**suspended**]** **SURRENDERED** or revoked for a period of more than 1 year, the Board may reinstate the license after 1 year if the licensee:

(i) Meets the requirements for reinstatement as established by the Board; and

(ii) **[**Submits to**]** **COMPLETES** a criminal history records check in accordance with § 14–308.1 of this title.

(b) An individual whose license has been **[**suspended**]** **SURRENDERED** or revoked under this title and who seeks reinstatement shall meet the continuing medical education requirements established for the renewal of licenses as if the individual were licensed during the period of **[**suspension**]** **SURRENDER** or revocation.

(c) If an order of **[**suspension or**]** revocation is based on § 14–404(b) of this subtitle, and the conviction or plea subsequently is overturned at any stage of an appeal or other postconviction proceeding, the **[**suspension or**]** revocation ends when the conviction

or plea is overturned.

14–411.1.

(b) The Board shall create and maintain a public individual profile on each licensee that includes the following information:

(1) A summary of charges filed against the licensee, including a copy of the charging document, until a disciplinary panel has taken action under § 14–404 of this subtitle based on the charges or has rescinded the charges;

(2) A description of any disciplinary action taken by the Board or a disciplinary panel against the licensee within the most recent 10–year period that includes a copy of the public order;

(3) A description in summary form of any final disciplinary action taken by a licensing board in any other state or jurisdiction against the licensee within the most recent 10–year period;

(4) **[**The number of medical malpractice final court judgments and arbitration awards against the licensee within the most recent 10–year period for which all appeals have been exhausted as reported to the Board;

(5)**]** A description of a conviction or entry of a plea of guilty or nolo contendere by the licensee for a crime involving moral turpitude reported to the Board under § 14–416 of this subtitle; and

[(6)**] (5)** As reported to the Board by the licensee, education and practice information about the licensee including:

(i) The name of any medical school that the licensee attended and the date on which the licensee graduated from the school;

(ii) A description of any internship and residency training;

(iii) A description of any specialty board certification by a recognized board of the American Board of Medical Specialties or the American Osteopathic Association;

(iv) The name of any hospital where the licensee has medical privileges;

(v) The location of the licensee's primary practice setting;

(vi) Whether the licensee participates in the Maryland Medical Assistance Program; **[**and**]**

(vii) Whether the licensee maintains medical professional liability insurance**; AND**

(VIII) THE NUMBER OF MEDICAL MALPRACTICE FINAL COURT JUDGMENTS AND ARBITRATION AWARDS AGAINST THE LICENSEE WITHIN THE MOST RECENT 10–YEAR PERIOD FOR WHICH ALL APPEALS HAVE BEEN EXHAUSTED.

14–412.

(a) If a person is a member of the Board or a legally authorized agent of the Board and is investigating, prosecuting, participating in a hearing, or otherwise acting on an allegation of a ground for Board action made to the Board **[**or the Faculty**]**, the person shall have the immunity from liability described under § 5–715(b) of the Courts and Judicial Proceedings Article.

(b) A person who makes an allegation of a ground for Board action to the Board **[**or the Faculty**]** shall have the immunity from liability described under § 5–715(c) of the Courts and Judicial Proceedings Article.

14–501.

(c) After the Secretary reviews the standards of appropriate accrediting organizations and consults with **[**the Faculty**]** **MEDCHI**, the Maryland Hospital Association, and the Maryland Association of Health Maintenance Organizations, the regulations adopted by the Secretary under subsection (b) of this section shall:

(1) Provide for a procedure for the collection and release of primary source verification information;

(2) Include standards by which any organization, including **[**the Faculty**]** **MEDCHI**, may qualify to perform primary source verification; and

(3) Provide for the monitoring by the Secretary of any organization that qualifies to administer primary source verification.

14–502.

(b) This section applies to:

(1) **[**The Faculty**]** **MEDCHI**;

(2) A component medical society of **[**the Faculty**]** **MEDCHI**;

(3) A committee of **[**the Faculty**]** **MEDCHI** or of a component medical society of **[**the Faculty**]** **MEDCHI**;

14–506.

(b) The following records and other information are confidential records:

(1) Any record and other information obtained by **[**the Faculty**]** **MEDCHI**, a component society of **[**the Faculty**]** **MEDCHI**, the Maryland Institute for Emergency Medical Services Systems, a hospital staff committee, or a national medical society or group organized for research, if that record or information identifies any person; and

14–5A–08.

(a) Except as otherwise provided in this subtitle, an individual shall be licensed by the Board before the individual may practice respiratory care in this State.

(b) This section does not apply to:

(1) An individual employed by the federal government as a respiratory care practitioner while the individual is practicing within the scope of that employment; **[**or**]**

(2) A respiratory care practitioner student enrolled in an education program which is accredited by an approved accrediting organization while practicing

respiratory care in the program**; OR**

(3) AN INDIVIDUAL PRACTICING RESPIRATORY CARE WHO IS LICENSED BY AND RESIDING IN ANOTHER JURISDICTION IF:

(I) THE INDIVIDUAL IS PARTICIPATING IN THE TRANSPORTATION OF A PATIENT FROM THAT INDIVIDUAL'S JURISDICTION OF LICENSURE INTO THE STATE;

(II) THE INDIVIDUAL PRACTICES RESPIRATORY CARE ONLY DURING THE TRANSPORTATION OF THE PATIENT; AND

(III) THE INDIVIDUAL DOES NOT PRACTICE RESPIRATORY CARE ON ANOTHER INDIVIDUAL WHO IS NOT THE PATIENT BEING TRANSPORTED INTO THE STATE.

14–5A–09.

(e) The applicant shall **[**submit to**]** **COMPLETE** a criminal history records check in accordance with § 14–308.1 of this title.

14–5A–10.

To apply for a license, an applicant shall:

(1) **[**Submit to**]** **COMPLETE** a criminal history records check in accordance with § 14–308.1 of this title;

14–5A–13.

(a) **(1) THE TERM OF A LICENSE ISSUED BY THE BOARD MAY NOT EXCEED 3 YEARS.**

(2) A license expires on a date set by the Board, unless the license is renewed for an additional term as provided in this section.

(c) Except as otherwise provided in this subtitle, before a license expires, the licensee periodically may renew it for an additional term, if the licensee:

(1) **IS OF GOOD MORAL CHARACTER;**

(2) Pays to the Board a renewal fee set by the Board;

[(2)**] (3)** Submits to the Board:

(i) A renewal application on the form that the Board requires; and

(ii) Satisfactory evidence of compliance with any continuing education or competency requirements and other requirements set under this section for license renewal; and

[(3)**] (4)** Meets any additional renewal requirements established by the Board.

(g) (1) Beginning October 1, 2016, the Board shall require a criminal history records check in accordance with § 14–308.1 of this title for:

(i) **[**Annual renewal**]** **RENEWAL** applicants as determined by regulations adopted by the Board; and

(ii) Each former licensee who files for reinstatement under subsection (f) of this section.

14–5A–17.

(a) Subject to the hearing provisions of § 14–405 of this title, a disciplinary panel, on the affirmative vote of a majority of a quorum of the disciplinary panel, may deny a license to any applicant, reprimand any licensee, place any licensee on probation, or suspend or revoke a license, if the applicant or licensee:

(28) Fails to **[**submit to**]** **COMPLETE** a criminal history records check under § 14–308.1 of this title.

(D) (1) IF, AFTER A HEARING UNDER § 14–405 OF THIS TITLE, A DISCIPLINARY PANEL FINDS THAT THERE ARE GROUNDS UNDER SUBSECTION (A) OF THIS SECTION TO SUSPEND OR REVOKE A LICENSE, TO REPRIMAND A LICENSEE, OR

TO PLACE A LICENSEE ON PROBATION, THE DISCIPLINARY PANEL MAY IMPOSE A FINE SUBJECT TO THE BOARD'S REGULATIONS IN ADDITION TO SUSPENDING OR REVOKING THE LICENSE, REPRIMANDING THE LICENSEE, OR PLACING THE LICENSEE ON PROBATION.

(2) THE BOARD SHALL PAY ANY FINES COLLECTED UNDER THIS SECTION INTO THE GENERAL FUND OF THE STATE.

(E) IN ADDITION TO ANY SANCTION AUTHORIZED UNDER THIS SECTION, A DISCIPLINARY PANEL MAY REQUIRE A LICENSEE TO COMPLY WITH SPECIFIED TERMS AND CONDITIONS DETERMINED BY THE DISCIPLINARY PANEL.

14–5A–19.

(c) A disciplinary panel may not reinstate a revoked license that has been revoked for a period of more than 1 year unless the licensee:

(2) **[**Submits to**]** **COMPLETES** a criminal history records check in accordance with § 14–308.1 of this title.

14–5A–22.1.

(c) **[**The Board**]** **A DISCIPLINARY PANEL** may impose a civil penalty of up to $1,000 for a violation of this section.

14–5A–23.

(a) A person who violates any provision of **§§ 14–5A–20 THROUGH 14–5A–22.1 OF** this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000 or imprisonment not exceeding 1 year or both.

(b) **[**Any**]** **A** person who violates **[**a**]** **ANY** provision **OF §§ 14–5A–20 THROUGH 14–5A–22.1** of this subtitle is subject to a civil fine of not more than $5,000 to be levied by a disciplinary panel.

14–5A–25.

Subject to the evaluation and reestablishment provisions of the Maryland Program

Evaluation Act and subject to the termination of this title under § 14–702 of this title, this subtitle and all rules and regulations adopted under this subtitle shall terminate and be of no effect after **[**June 1, 2020**]** **JULY 1, 2030**.

Subtitle 5B. Radiation **[**Oncology/Therapy**]** **THERAPY**, **[**Medical Radiation, and**]** **RADIOGRAPHY,** Nuclear Medicine **[**Technologists**]** **TECHNOLOGY, AND RADIOLOGY ASSISTANCE**.

14–5B–01.

(a) In this subtitle the following words have the meanings indicated.

(q) "Supervision" means the responsibility of a licensed physician to exercise on–site or immediately available direction for licensees **[**or holders of temporary licenses**]**.

14–5B–04.

(a) (1) The Board shall set reasonable fees for the issuance of and renewal of licenses and other services it provides to licensees **[**and holders of temporary licenses**]**.

(2) The fees charged shall be set so as to produce funds to approximate the cost of maintaining the licensure program and the other services provided to licensees **[**and holders of temporary licenses**]**, including the cost of providing a rehabilitation program for licensees **[**and holders of temporary licenses**]** under § 14–401.1(g) of this title.

14–5B–05.

(b) (1) The Committee consists of **[**10**]** **NINE** members appointed by the Board.

(2) Of the **[**10**]** **NINE** members:

(i) One shall be a licensed physician who specializes in radiology;

(ii) One shall be a licensed physician who specializes in radiology and who supervises a radiologist assistant;

(iii) One shall be a licensed physician who specializes in nuclear medicine;

(iv) One shall be a licensed physician who specializes in radiation oncology;

(v) One shall be a radiation therapist;

(vi) One shall be a radiographer;

(vii) One shall be a radiologist assistant;

(viii) One shall be a nuclear medicine technologist; **AND**

(ix) One shall be a consumer member**[**; and

(x) One shall be a member of the Board**]**.

14–5B–09.

(b) Except as provided in subsection (c) of this section, the applicant shall:

(5) **[**Submit to**]** **COMPLETE** a criminal history records check in accordance with § 14–308.1 of this title.

14–5B–10.

(a) To apply for a license, an applicant shall:

(1) **[**Submit to**]** **COMPLETE** a criminal history records check in accordance with § 14–308.1 of this title;

14–5B–12.

(a) **(1) THE TERM OF A LICENSE ISSUED BY THE BOARD MAY NOT EXCEED 3 YEARS.**

(2) A license expires on a date set by the Board, unless the license is renewed for an additional term as provided in this section.

(c) Except as otherwise provided in this subtitle, before a license expires, the licensed individual may periodically renew it for an additional term, if the individual:

(1) **IS OF GOOD MORAL CHARACTER;**

(2) Pays to the Board a renewal fee set by the Board;

[(2)**] (3)** Submits to the Board:

(i) A renewal application on the form that the Board requires; and

(ii) Satisfactory evidence of compliance with any continuing education or competency requirements and other requirements required by the Board for license renewal; and

[(3)**] (4)** Meets any additional renewal requirements established by the Board.

(f) The Board shall reinstate the license of a radiation therapist, radiographer, nuclear medicine technologist, or radiologist assistant who has failed to renew a license for any reason if the radiation therapist, radiographer, nuclear medicine technologist, or radiologist assistant:

(1) MEETS THE RENEWAL REQUIREMENTS OF THIS SECTION;

[(1)**] (2)** Submits to the Board:

(i) A reinstatement application on the form that the Board requires; and

(ii) Satisfactory evidence of compliance with any continuing education or competency requirements; and

[(2)**] (3)** Meets any additional requirements established by the Board for reinstatement.

(g) (1) Beginning October 1, 2016, the Board shall require a criminal history records check in accordance with § 14–308.1 of this title for:

(i) **[**Annual renewal**]** **RENEWAL** applicants as determined by regulations adopted by the Board; and

14–5B–14.

(a) Subject to the hearing provisions of § 14–405 of this title, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may deny a license to any applicant, reprimand any licensee, place any licensee on probation, or suspend or revoke a license, if the applicant or licensee:

(28) Fails to **[**submit to**]** **COMPLETE** a criminal history records check under § 14–308.1 of this title.

(D) (1) IF, AFTER A HEARING UNDER § 14–405 OF THIS TITLE, A DISCIPLINARY PANEL FINDS THAT THERE ARE GROUNDS UNDER SUBSECTION (A) OF THIS SECTION TO SUSPEND OR REVOKE A LICENSE, TO REPRIMAND A LICENSEE, OR TO PLACE A LICENSEE ON PROBATION, THE DISCIPLINARY PANEL MAY IMPOSE A FINE SUBJECT TO THE BOARD'S REGULATIONS IN ADDITION TO SUSPENDING OR REVOKING THE LICENSE, REPRIMANDING THE LICENSEE, OR PLACING THE LICENSEE ON PROBATION.

(2) THE BOARD SHALL PAY ANY FINES COLLECTED UNDER THIS SECTION INTO THE GENERAL FUND OF THE STATE.

(E) IN ADDITION TO ANY SANCTION AUTHORIZED UNDER THIS SECTION, A DISCIPLINARY PANEL MAY REQUIRE A LICENSEE TO COMPLY WITH SPECIFIED TERMS AND CONDITIONS DETERMINED BY THE DISCIPLINARY PANEL.

14–5B–16.

(c) A disciplinary panel may not reinstate a revoked license that has been revoked for a period of more than 1 year unless the licensee:

(2) **[**Submits to**]** **COMPLETES** a criminal history records check in accordance with § 14–308.1 of this title.

14–5B–18.1.

(c) **[**The Board**]** **A DISCIPLINARY PANEL** may impose a civil penalty of up to $1,000 for employing an individual without a license under this section.

14–5B–19.

(a) A person who violates any provision of **§§ 14–5B–17 THROUGH 14–5B–18.1 OF** this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000 or imprisonment not exceeding 1 year or both.

(b) **[**Any**]** **A** person who violates **ANY PROVISION OF §§ 14–5B–17 THROUGH 14–5B–18.1 OF** this subtitle is subject to a civil fine of not more than $5,000 to be levied by **[**the Board**]** **A DISCIPLINARY PANEL**.

14–5B–21.

Subject to the evaluation and reestablishment provisions of the Maryland Program Evaluation Act, and subject to the termination of this title under § 14–702 of this title, this subtitle and all rules and regulations adopted under this subtitle shall terminate and be of no effect after **[**June 1, 2020**]** **JULY 1, 2030**.

14–5C–09.

(b) The applicant shall:

(3) **[**Submit to**]** **COMPLETE** a criminal history records check in accordance with § 14–308.1 of this title.

14–5C–11.

To apply for a license, an applicant shall:

(1) **[**Submit to**]** **COMPLETE** a criminal history records check in accordance with § 14–308.1 of this title;

14–5C–14.

(a) **(1) THE TERM OF A LICENSE ISSUED BY THE BOARD MAY NOT EXCEED**

3 YEARS.

(2) A license expires on a date set by the Board, unless the license is renewed for an additional term as provided in this section.

(c) Except as otherwise provided in this subtitle, before a license expires, the licensed polysomnographic technologist periodically may renew it for an additional term, if the licensee:

(1) Otherwise is entitled to be licensed;

(2) IS OF GOOD MORAL CHARACTER;

[(2)**] (3)** Pays to the Board a renewal fee set by the Board; and

[(3)**] (4)** Submits to the Board:

(i) A renewal application on the form that the Board requires; and

(ii) Satisfactory evidence of compliance with any continuing education or competency requirements and other requirements set under this section for license renewal.

(g) (1) Beginning October 1, 2016, the Board shall require a criminal history records check in accordance with § 14–308.1 of this title for:

(i) **[**Annual renewal**]** **RENEWAL** applicants as determined by regulations adopted by the Board; and

(ii) Each former licensee who files for reinstatement under subsection (f) of this section.

14–5C–17.

(a) Subject to the hearing provisions of § 14–405 of this title, a disciplinary panel, on the affirmative vote of a majority of a quorum of the disciplinary panel, may deny a license to any applicant, reprimand any licensee, place any licensee on probation, or suspend or revoke a license, if the applicant or licensee:

[(25) Is convicted of or pleads guilty or nolo contendere to a felony or to a crime involving moral turpitude, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside;**]**

[(26)**] (25)** Refuses, withholds from, denies, or discriminates against an individual with regard to the provision of professional services for which the licensee is licensed and qualified to render because the individual is HIV positive;

[(27)**] (26)** Practices or attempts to practice a polysomnography procedure or uses or attempts to use polysomnography equipment if the applicant or licensee has not received education and training in the performance of the procedure or the use of the equipment;

[(28)**] (27)** Fails to cooperate with a lawful investigation conducted by the Board; or

[(29)**] (28)** Fails to **[**submit to**] COMPLETE** a criminal history records check under § 14–308.1 of this title.

(D) (1) IF, AFTER A HEARING UNDER § 14–405 OF THIS TITLE, A DISCIPLINARY PANEL FINDS THAT THERE ARE GROUNDS UNDER SUBSECTION (A) OF THIS SECTION TO SUSPEND OR REVOKE A LICENSE, TO REPRIMAND A LICENSEE, OR TO PLACE A LICENSEE ON PROBATION, THE DISCIPLINARY PANEL MAY IMPOSE A FINE SUBJECT TO THE BOARD'S REGULATIONS IN ADDITION TO SUSPENDING OR REVOKING THE LICENSE, REPRIMANDING THE LICENSEE, OR PLACING THE LICENSEE ON PROBATION.

(2) THE BOARD SHALL PAY ANY FINES COLLECTED UNDER THIS SECTION INTO THE GENERAL FUND OF THE STATE.

(E) IN ADDITION TO ANY SANCTION AUTHORIZED UNDER THIS SECTION, A DISCIPLINARY PANEL MAY REQUIRE A LICENSEE TO COMPLY WITH SPECIFIED TERMS AND CONDITIONS DETERMINED BY THE DISCIPLINARY PANEL.

14–5C–19.

(c) A disciplinary panel may not reinstate a revoked license that has been revoked

for a period of more than 1 year unless the licensee:

(2) **[**Submits to**]** **COMPLETES** a criminal history records check in accordance with § 14–308.1 of this title.

14–5C–22.1.

(c) **[**The Board**]** **A DISCIPLINARY PANEL** may impose a civil penalty of not more than $5,000 for a violation of this section.

14–5C–23.

(a) A person who violates any provision of **§§ 14–5C–20 THROUGH 14–5C–22.1 OF** this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000 or imprisonment not exceeding 1 year or both.

(b) **[**Any**]** **A** person who violates **[**a**]** **ANY** provision **OF §§ 14–5C–20 THROUGH 14–5C–22.1** of this subtitle is subject to a civil fine of not more than $5,000 to be levied by **[**the Board**]** **A DISCIPLINARY PANEL**.

14–5C–25.

Subject to the evaluation and reestablishment provisions of the Maryland Program Evaluation Act and subject to the termination of this title under § 14–702 of this title, this subtitle and all regulations adopted under this subtitle shall terminate and be of no effect after **[**June 1, 2020**]** **JULY 1, 2030**.

14–5D–05.

(a) The Committee consists of **[**11**]** **NINE** members appointed by the Board as follows:

(1) (i) On or before September 30, 2011, three athletic trainers who:

1. Are certified by a national certifying board; and

2. Have a minimum of 5 years of clinical experience; and

(ii) On or after October 1, 2011, three licensed athletic trainers who:

1. Are certified by a national certifying board; and

2. Have a minimum of 5 years of clinical experience;

(2) Three licensed physicians:

(i) At least one of whom is a specialist in orthopedic or sports medicine; and

(ii) Two of whom previously or currently have partnered with or directed an athletic trainer;

(3) One **MEMBER WHO IS:**

(I) **A** licensed chiropractor who has sports medicine experience;

[(4)**]** **(II)** **[**One**]** **A** licensed physical therapist; **OR**

[(5)**]** **(III)** **[**One**]** **A** licensed occupational therapist; and

[(6)**]** **(4)** Two consumer members.

14–5D–08.

(b) The applicant shall:

(3) **[**Submit to**]** **COMPLETE** a criminal history records check in accordance with § 14–308.1 of this title.

14–5D–09.

(a) To apply for a license, an applicant shall:

(1) **[**Submit to**]** **COMPLETE** a criminal history records check in accordance with § 14–308.1 of this title;

14–5D–11.

(b) Before an athletic trainer may practice athletic training, the athletic trainer shall:

(1) Obtain a license under this subtitle;

(2) Enter into a written evaluation and treatment protocol with a licensed physician; and

(3) Except as provided in § 14–5D–11.3(a) of this subtitle, **[**obtain Board approval of**]** **SUBMIT A COPY OF** the evaluation and treatment protocol **FOR BOARD APPROVAL**.

(e) **(1)** In the event of a sudden departure, incapacity, or death of a supervising physician, **OR CHANGE IN LICENSE STATUS THAT RESULTS IN THE PRIMARY SUPERVISING PHYSICIAN BEING UNABLE TO LEGALLY PRACTICE MEDICINE,** a designated alternate supervising physician may assume the role of the supervising physician by submitting an evaluation and treatment protocol to the Board within 15 days of the event.

(2) THE BOARD MAY TERMINATE AN EVALUATION AND TREATMENT PROTOCOL IF:

(I) THE ATHLETIC TRAINER HAS A CHANGE IN LICENSE STATUS THAT RESULTS IN THE ATHLETIC TRAINER BEING UNABLE TO LEGALLY PRACTICE ATHLETIC TRAINING; OR

(II) THE SUPERVISING PHYSICIAN HAS A CHANGE IN LICENSE STATUS THAT RESULTS IN THE PHYSICIAN BEING UNABLE TO LEGALLY PRACTICE MEDICINE AND AN ALTERNATE SUPERVISING PHYSICIAN DOES NOT ASSUME THE ROLE OF SUPERVISING PHYSICIAN UNDER PARAGRAPH (1) OF THIS SUBSECTION.

14–5D–11.3.

(a) (1) An athletic trainer may assume the duties under an evaluation and treatment protocol **[**after receiving a written recommendation of approval from the Committee if**]** **ON THE DATE THAT THE BOARD ACKNOWLEDGES RECEIPT OF THE**

COMPLETED EVALUATION AND TREATMENT PROTOCOL APPROPRIATE TO THE SCOPE OF PRACTICE IF THE PROTOCOL IS GIVEN PRELIMINARY APPROVAL BY BOARD STAFF AND:

(i) The evaluation and treatment protocol does not include specialized tasks; or

(ii) The evaluation and treatment protocol includes specialized tasks that the Board previously has approved under § 14–5D–11 of this subtitle.

(2) If an evaluation and treatment protocol includes specialized tasks that have not been previously approved by the Board under § 14–5D–11 of this subtitle, an athletic trainer may only perform the specialized task after receiving written approval from the Board.

(b) The Board may disapprove an evaluation and treatment protocol or a specialized task included in the evaluation and treatment protocol if the Board determines that:

(1) The evaluation and treatment protocol does not meet the requirements of § 14–5D–11(c) of this subtitle;

(2) The athletic trainer is unable to perform the specialized task safely; or

(3) The specialized task is outside the practice scope of an athletic trainer.

(c) If the Board disapproves an evaluation and treatment protocol or a specialized task included in an evaluation and treatment protocol, the Board shall send to the primary supervising physician and the athletic trainer written notice of the disapproval.

(d) An athletic trainer who receives notice of a disapproval under subsection (c) of this section shall immediately cease practicing under the evaluation and treatment protocol or performing the specialized task.

(e) An individual member of the Board is not civilly liable for any act or omission relating to the approval, modification, or disapproval of an evaluation and treatment protocol.

14–5D–12.

(a) **(1) THE TERM OF A LICENSE ISSUED BY THE BOARD MAY NOT EXCEED 3 YEARS.**

(2) A license expires on a date set by the Board, unless the license is renewed for an additional term as provided in this section.

(c) Except as otherwise provided in this subtitle, before a license expires, the licensee periodically may renew it for an additional term, if the licensee:

(1) Otherwise is entitled to be licensed;

(2) IS OF GOOD MORAL CHARACTER;

[(2)**] (3)** Pays to the Board a renewal fee set by the Board; and

[(3)**] (4)** Submits to the Board:

(i) A renewal application on the form that the Board requires;

(ii) Satisfactory evidence of compliance with any continuing education or competency requirements; and

(iii) Any other requirements set under this section for license renewal.

(h) (1) Beginning October 1, 2016, the Board shall require a criminal history records check in accordance with § 14–308.1 of this title for:

(i) **[**Annual renewal**]** **RENEWAL** applicants as determined by regulations adopted by the Board; and

(ii) Each former licensee who files for reinstatement under subsection (f) of this section.

14–5D–14.

(a) Subject to the hearing provisions of § 14–405 of this title, a disciplinary panel, on the affirmative vote of a majority of a quorum of the disciplinary panel, may deny a license to any applicant, reprimand any licensee, place any licensee on probation, or suspend or revoke a license, if the applicant or licensee:

(29) Fails to **[**submit to**]** **COMPLETE** a criminal history records check under § 14–308.1 of this title.

(D) (1) IF, AFTER A HEARING UNDER § 14–405 OF THIS TITLE, A DISCIPLINARY PANEL FINDS THAT THERE ARE GROUNDS UNDER SUBSECTION (A) OF THIS SECTION TO SUSPEND OR REVOKE A LICENSE, TO REPRIMAND A LICENSEE, OR TO PLACE A LICENSEE ON PROBATION, THE DISCIPLINARY PANEL MAY IMPOSE A FINE SUBJECT TO THE BOARD'S REGULATIONS IN ADDITION TO SUSPENDING OR REVOKING THE LICENSE, REPRIMANDING THE LICENSEE, OR PLACING THE LICENSEE ON PROBATION.

(2) THE BOARD SHALL PAY ANY FINES COLLECTED UNDER THIS SECTION INTO THE GENERAL FUND OF THE STATE.

(E) IN ADDITION TO ANY SANCTION AUTHORIZED UNDER THIS SECTION, A DISCIPLINARY PANEL MAY REQUIRE A LICENSEE TO COMPLY WITH SPECIFIED TERMS AND CONDITIONS DETERMINED BY THE DISCIPLINARY PANEL.

14–5D–15.

(a) (1) Except as otherwise provided in § 10–226 of the State Government Article, before the Board or a disciplinary panel takes any action under § 14–5D–14 of this subtitle, the Board or the disciplinary panel shall give the individual against whom the action is contemplated an opportunity for a hearing before a hearing officer.

(2) The hearing officer shall give notice and hold the hearing in accordance with Title 10, Subtitle 2 of the State Government Article.

(3) The Board or a disciplinary panel may administer oaths in connection with any proceedings under this section.

[(4) At least 14 days before the hearing, a hearing notice shall be sent by certified mail to the last known address of the individual.**]**

(b) (1) Any person aggrieved by a final decision of the Board or a disciplinary panel under this subtitle may take a direct judicial appeal.

(2) The appeal shall be made as provided for judicial review of final decisions in the Administrative Procedure Act.

(c) An order of the Board or a disciplinary panel may not be stayed pending review.

(d) The Board may appeal from any decision that reverses or modifies an order of the Board or a disciplinary panel.

14–5D–16.

(c) A disciplinary panel may not reinstate a revoked license that has been revoked for a period of more than 1 year unless the licensee:

(2) **[**Submits to**]** **COMPLETES** a criminal history records check in accordance with § 14–308.1 of this title.

14–5D–18.

(a) A person who violates **[**any provision**] § 14–5D–17** of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000 or imprisonment not exceeding 1 year or both.

(b) **[**Any**] A** person who violates **[**any provision**] § 14–5D–17** of this subtitle is subject to a civil fine of not more than $5,000 to be levied by a disciplinary panel.

14–5D–20.

Subject to the evaluation and reestablishment provisions of the Maryland Program Evaluation Act and subject to the termination of this title under § 14–702 of this title, this subtitle and all rules and regulations adopted under this subtitle shall terminate and be of no effect after **[**June 1, 2020**] JULY 1, 2030**.

14–5E–09.

(b) The applicant shall:

(3) **[**Submit to**]** **COMPLETE** a criminal history records check in accordance with § 14–308.1 of this title.

14–5E–11.

(a) To apply for a license, an applicant shall:

(1) **[**Submit to**]** **COMPLETE** a criminal history records check in accordance with § 14–308.1 of this title;

14–5E–13.

(a) (1) A license expires on a date set by the Board, unless the license is renewed for an additional term as provided in this section.

(2) **[**A**]** **THE TERM OF A** license **ISSUED BY THE BOARD** may not **[**be renewed for a term longer than 2**]** **EXCEED 3** years.

(c) (1) Except as otherwise provided in this subtitle, before a license expires, the licensed perfusionist periodically may renew it for an additional term, if the licensee:

(i) Otherwise is entitled to be licensed;

(II) IS OF GOOD MORAL CHARACTER;

[(ii)**]** **(III)** Pays to the Board a renewal fee set by the Board; and

[(iii)**]** **(IV)** Except as provided in paragraph (2) of this subsection, submits to the Board:

1. A renewal application on the form that the Board requires; and

2. Satisfactory evidence of compliance with any continuing education or competency requirements and other requirements set under this section for license renewal.

(g) (1) Beginning October 1, 2016, the Board shall require a criminal history records check in accordance with § 14–308.1 of this title for:

(i) **[**Annual renewal**]** **RENEWAL** applicants as determined by regulations adopted by the Board; and

(ii) Each former licensee who files for reinstatement under subsection (f) of this section.

14–5E–16.

(a) Subject to the hearing provisions of § 14–405 of this title, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may deny a license to any applicant, reprimand any licensee, place any licensee on probation, or suspend or revoke a license, if the applicant or licensee:

[(25) Is convicted of or pleads guilty or nolo contendere to a felony or to a crime involving moral turpitude, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside;**]**

[(26)**] (25)** Refuses, withholds from, denies, or discriminates against an individual with regard to the provision of professional services for which the licensee is licensed and qualified to render because the individual is HIV positive;

[(27)**] (26)** Practices or attempts to practice a perfusion procedure or uses or attempts to use perfusion equipment if the applicant or licensee has not received education and training in the performance of the procedure or the use of the equipment;

[(28)**] (27)** Fails to cooperate with a lawful investigation of the Board or a disciplinary panel; or

[(29)**] (28)** Fails to **[**submit to**]** **COMPLETE** a criminal history records check under § 14–308.1 of this title.

(D) (1) IF, AFTER A HEARING UNDER § 14–405 OF THIS TITLE, A DISCIPLINARY PANEL FINDS THAT THERE ARE GROUNDS UNDER SUBSECTION (A) OF THIS SECTION TO SUSPEND OR REVOKE A LICENSE, TO REPRIMAND A LICENSEE, OR

PLACE A LICENSEE ON PROBATION, THE DISCIPLINARY PANEL MAY IMPOSE A FINE SUBJECT TO THE BOARD'S REGULATIONS IN ADDITION TO SUSPENDING OR REVOKING THE LICENSE, REPRIMANDING THE LICENSEE, OR PLACING THE LICENSEE ON PROBATION.

(2) THE BOARD SHALL PAY ANY FINES COLLECTED UNDER THIS SECTION INTO THE GENERAL FUND.

(E) IN ADDITION TO ANY SANCTION AUTHORIZED UNDER THIS SECTION, A DISCIPLINARY PANEL MAY REQUIRE A LICENSEE TO COMPLY WITH SPECIFIED TERMS AND CONDITIONS DETERMINED BY THE DISCIPLINARY PANEL.

14–5E–19.

(c) A disciplinary panel may not reinstate a revoked license that has been revoked for a period of more than 1 year unless the licensee:

(2) **[**Submits to**]** **COMPLETES** a criminal history records check in accordance with § 14–308.1 of this title.

14–5E–23.

(a) A person who violates any provision of **§§ 14–5E–20 THROUGH 14–5E–22 OF** this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $1,000 or imprisonment not exceeding 1 year or both.

(b) A person who violates any provision of **§§ 14–5E–20 THROUGH 14–5E–22 OF** this subtitle is subject to a civil fine of not more than $5,000 to be levied by a disciplinary panel.

14–5E–25.

Subject to the evaluation and reestablishment provisions of the Maryland Program Evaluation Act and subject to the termination of this title under § 14–702 of this title, this subtitle and all regulations adopted under this subtitle shall terminate and be of no effect after **[**June 1, 2020**]** **JULY 1, 2030**.

14–5F–04.1.

(a) (2) The Council consists of the following members:

(ii) The following members, appointed by the Board:

2. Two licensed physicians **[**or doctors of osteopathy**]** who practice in the State;

14–5F–07.

(a) (1) The Committee consists of five members appointed by the Board as follows:

(i) Two shall be individuals who practice naturopathic medicine and who:

1. On or after October 1, 2014:

A. Are certified by the North American Board of Naturopathic Examiners; and

B. Have a minimum of 2 years experience; and

2. On or after March 1, 2016, are licensed naturopathic doctors;

(ii) One shall be a practicing licensed physician **[**or practicing doctor of osteopathy who is a member of the Board**]**;

(iii) One shall be a practicing licensed physician **[**or practicing licensed doctor of osteopathy**]** with experience working with naturopathic doctors; and

(iv) One shall be a consumer member.

(c) The physician **[**or doctor of osteopathy**]** members of the Committee shall be in good standing with the Board.

14–5F–11.

(g) An applicant shall **[**submit to**]** **COMPLETE** a criminal history records check in accordance with § 14–308.1 of this title.

14–5F–12.

To apply for a license, an applicant shall:

(1) **[**Submit to**]** **COMPLETE** a criminal history records check in accordance with § 14–308.1 of this title;

14–5F–15.

(a) (1) The term of a license issued by the Board **[**is 2**]** **MAY NOT EXCEED 3** years.

(2) A license expires **[**at the end of its term**]** **ON A DATE SET BY THE BOARD,** unless the license is renewed as provided **[**by the Board**]** **IN THIS SECTION**.

(c) The Board shall renew the license of a licensee who:

(1) Submits a renewal application on the form that the Board requires;

(2) IS OF GOOD MORAL CHARACTER;

[(2)**]** **(3)** Pays a renewal fee set by the Board;

[(3)**]** **(4)** Is otherwise entitled to be licensed;

[(4)**]** **(5)** Meets the continuing education requirements adopted by the Board; and

[(5)**]** **(6)** Provides evidence of biennial cardiopulmonary resuscitation certification.

(d) (1) Beginning October 1, 2016, the Board shall require a criminal history records check in accordance with § 14–308.1 of this title for:

(i) **[**Annual renewal**]** **RENEWAL** applicants as determined by regulations adopted by the Board; and

14–5F–18.

(a) Subject to the hearing provisions of § 14–405 of this title, a disciplinary panel, on the affirmative vote of a majority of a quorum of the disciplinary panel, may deny a license to any applicant, reprimand any licensee, place any licensee on probation, or suspend or revoke a license of any licensee if the applicant or licensee:

(27) Fails to **[**submit to**]** **COMPLETE** a criminal history records check under § 14–308.1 of this title.

(D) (1) IF, AFTER A HEARING UNDER § 14–405 OF THIS TITLE, A DISCIPLINARY PANEL FINDS THAT THERE ARE GROUNDS UNDER SUBSECTION (A) OF THIS SECTION TO SUSPEND OR REVOKE A LICENSE, TO REPRIMAND A LICENSEE, OR TO PLACE A LICENSEE ON PROBATION, THE DISCIPLINARY PANEL MAY IMPOSE A FINE SUBJECT TO THE BOARD'S REGULATIONS IN ADDITION TO SUSPENDING OR REVOKING THE LICENSE, REPRIMANDING THE LICENSEE, OR PLACING THE LICENSEE ON PROBATION.

(2) THE BOARD SHALL PAY ANY FINES COLLECTED UNDER THIS SECTION INTO THE GENERAL FUND.

(E) IN ADDITION TO ANY SANCTION AUTHORIZED UNDER THIS SECTION, A DISCIPLINARY PANEL MAY REQUIRE A LICENSEE TO COMPLY WITH SPECIFIED TERMS AND CONDITIONS DETERMINED BY THE DISCIPLINARY PANEL.

14–5F–22.

[(a)**]** If the Board or a disciplinary panel finds that there are grounds for action under § 14–5F–18 of this subtitle, the Board or the disciplinary panel shall pass an order in accordance with the Administrative Procedure Act.

[(b) (1) If a license is revoked or suspended, the holder shall surrender the license to the Board on demand.

(2) At the end of a suspension period, the Board shall return to the licensee

any license surrendered under this section.**]**

14–5F–24.

(c) A disciplinary panel may not reinstate a **[**suspended**]** **SURRENDERED** or revoked license that has been **[**suspended**]** **SURRENDERED** or revoked for a period of more than 1 year unless the licensee:

(1) Meets the requirements for reinstatement as established under this title; and

(2) **[**Submits to**]** **COMPLETES** a criminal history records check in accordance with § 14–308.1 of this title.

14–5F–29.

(a) Except as otherwise provided in this subtitle, an individual may not practice, attempt to practice, or offer to practice naturopathic medicine in this State without a license.

(b) An individual who violates **[**any provision**]** **SUBSECTION (A) OF THIS SECTION OR § 14–5F–30** of this subtitle is guilty of a felony and on conviction is subject to a fine not exceeding $10,000 or imprisonment not exceeding 5 years or both.

(c) Any individual who violates **[**a provision**]** **SUBSECTION (A) OF THIS SECTION OR § 14–5F–30** of this subtitle is subject to a civil fine of not more than $50,000 to be levied by a disciplinary panel.

(d) The Board shall pay any penalty collected under this section into the Board of Physicians Fund.

14–5F–32.

Subject to the evaluation and reestablishment provisions of the Program Evaluation Act, this subtitle and all rules and regulations adopted under this subtitle shall terminate and be of no effect after **[**June 1, 2020**]** **JULY 1, 2030**.

14–602.

(b) Except as otherwise provided in this article, a person may not use the words or terms "Dr.", "doctor", "physician", "D.O.", or "M.D." with the intent to represent that the person practices medicine, unless the person is:

(5) An individual in a postgraduate medical program that is **[**approved**]** **ACCREDITED BY AN ACCREDITING ORGANIZATION RECOGNIZED** by the Board **IN REGULATIONS WHILE THE INDIVIDUAL IS PRACTICING MEDICINE IN THE PROGRAM**.

14–702.

Subject to the evaluation and reestablishment provisions of the Program Evaluation Act, this title and all rules and regulations adopted under this title shall terminate and be of no effect after **[**June 1, 2020**]** **JULY 1, 2030**.

15–103.

(b) **(1)** **[**An**]** **SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, AN** employer of a physician assistant shall report to the Board, on the form prescribed by the Board, any termination of employment of the physician assistant if the cause of termination is related to a quality of care issue.

(2) SUBJECT TO SUBSECTION (D) OF THIS SECTION, A SUPERVISING PHYSICIAN OR AN EMPLOYER OF A PHYSICIAN ASSISTANT SHALL NOTIFY THE BOARD WITHIN 10 DAYS OF THE TERMINATION OF EMPLOYMENT OF THE PHYSICIAN ASSISTANT FOR REASONS THAT WOULD BE GROUNDS FOR DISCIPLINE UNDER THIS SUBTITLE.

(3) A SUPERVISING PHYSICIAN AND A PHYSICIAN ASSISTANT SHALL NOTIFY THE BOARD OF THE TERMINATION OF THE RELATIONSHIP UNDER A DELEGATION AGREEMENT FOR ANY REASON.

15–202.

(a) (1) The Committee shall consist of 7 members appointed by the Board.

(2) Of the 7 Committee members:

(i) 3 shall be licensed physicians;

(ii) 3 shall be licensed physician assistants; and

(iii) 1 shall be a consumer.

(3) Of the licensed physician members:

(i) At least 1 shall specialize in general surgery or a surgical subspecialty; **AND**

(ii) At least 1 shall specialize in internal medicine, family practice, or a similar primary care specialty**[**; and

(iii) 1 shall be a Board member**]**.

15–203.

[(a)**]** The Board shall adopt regulations governing:

(1) The term of office for Committee members;

(2) The procedure for filling vacancies on the Committee;

(3) The removal of Committee members; and

(4) The duties of each officer.

[(b) In addition to the regulations on removal of members adopted by the Board, upon the recommendation of the Board the Governor may remove a member whom the Board finds to have been absent from 2 successive Committee meetings without adequate reason.**]**

15–302.

(a) A physician may delegate medical acts to a physician assistant only after:

(1) A delegation agreement has been executed and filed with the Board;

and

(2) Any advanced duties have been authorized as required under subsection (c) of this section.

(b) The delegation agreement shall contain:

(1) A description of the qualifications of the primary supervising physician and physician assistant;

(2) A description of the settings in which the physician assistant will practice;

(3) A description of the continuous physician supervision mechanisms that are reasonable and appropriate to the practice setting;

(4) A description of the delegated medical acts that are within the primary or alternate supervising physician's scope of practice and require specialized education or training that is consistent with accepted medical practice;

(5) An attestation that all medical acts to be delegated to the physician assistant are within the scope of practice of the primary or alternate supervising physician and appropriate to the physician assistant's education, training, and level of competence;

(6) An attestation of continuous supervision of the physician assistant by the primary supervising physician through the mechanisms described in the delegation agreement;

(7) An attestation by the primary supervising physician of the physician's acceptance of responsibility for any care given by the physician assistant;

(8) A description prepared by the primary supervising physician of the process by which the physician assistant's practice is reviewed appropriate to the practice setting and consistent with current standards of acceptable medical practice;

(9) An attestation by the primary supervising physician that the physician will respond in a timely manner when contacted by the physician assistant;

(10) The following statement: "The primary supervising physician and the physician assistant attest that:

(i) They will establish a plan for the types of cases that require a physician plan of care or require that the patient initially or periodically be seen by the supervising physician; and

(ii) The patient will be provided access to the supervising physician on request"; and

(11) Any other information deemed necessary by the Board to carry out the provisions of this subtitle.

(c) (1) The Board may not require prior approval of a delegation agreement that includes advanced duties, if an advanced duty will be performed in a hospital or ambulatory surgical facility, provided that:

(i) A physician, with credentials that have been reviewed by the hospital or ambulatory surgical facility as a condition of employment, as an independent contractor, or as a member of the medical staff, supervises the physician assistant;

(ii) The physician assistant has credentials that have been reviewed by the hospital or ambulatory surgical facility as a condition of employment, as an independent contractor, or as a member of the medical staff; and

(iii) Each advanced duty to be delegated to the physician assistant is reviewed and approved within a process approved by the governing body of the health care facility before the physician assistant performs the advanced duties.

(2) (i) In any setting that does not meet the requirements of paragraph (1) of this subsection, a primary supervising physician shall obtain the Board's approval of a delegation agreement that includes advanced duties, before the physician assistant performs the advanced duties.

(ii) 1. Before a physician assistant may perform X–ray duties authorized under § 14–306(e) of this article in the medical office of the physician delegating the duties, a primary supervising physician shall obtain the Board's approval of a delegation agreement that includes advanced duties in accordance with subsubparagraph

2 of this subparagraph.

2. The advanced duties set forth in a delegation agreement under this subparagraph shall be limited to nonfluoroscopic X–ray procedures of the extremities, anterior–posterior and lateral, not including the head.

(3) Notwithstanding paragraph (1) of this subsection, a primary supervising physician shall obtain the Board's approval of a delegation agreement before the physician assistant may administer, monitor, or maintain general anesthesia or neuroaxial anesthesia, including spinal and epidural techniques, under the agreement.

(d) For a delegation agreement containing advanced duties that require Board approval, the Committee shall review the delegation agreement and recommend to the Board that the delegation agreement be approved, rejected, or modified to ensure conformance with the requirements of this title.

(e) The Committee may conduct a personal interview of the primary supervising physician and the physician assistant.

(f) (1) On review of the Committee's recommendation regarding a primary supervising physician's request to delegate advanced duties as described in a delegation agreement, the Board:

(i) May approve the delegation agreement; or

(ii) 1. If the physician assistant does not meet the applicable education, training, and experience requirements to perform the specified delegated acts, may modify or disapprove the delegation agreement; and

2. If the Board takes an action under item 1 of this item:

A. Shall notify the primary supervising physician and the physician assistant in writing of the particular elements of the proposed delegation agreement that were the cause for the modification or disapproval; and

B. May not restrict the submission of an amendment to the delegation agreement.

(2) To the extent practicable, the Board shall approve a delegation agreement or take other action authorized under this subsection within 90 days after receiving a completed delegation agreement including any information from the physician assistant and primary supervising physician necessary to approve or take action.

(g) If the Board determines that a primary or alternate supervising physician or physician assistant is practicing in a manner inconsistent with the requirements of this title or Title 14 of this article, the Board on its own initiative or on the recommendation of the Committee may demand modification of the practice, withdraw the approval of the delegation agreement, or refer the matter to a disciplinary panel for the purpose of taking other disciplinary action under § 14–404 or § 15–314 of this article.

(h) A primary supervising physician may not delegate medical acts under a delegation agreement to more than four physician assistants at any one time, except in a hospital or in the following nonhospital settings:

(1) A correctional facility;

(2) A detention center; or

(3) A public health facility.

(i) A person may not coerce another person to enter into a delegation agreement under this subtitle.

(j) A physician may supervise a physician assistant:

(1) As a primary supervising physician in accordance with a delegation agreement approved by the Board under this subtitle; or

(2) As an alternate supervising physician if:

(i) The alternate supervising physician supervises in accordance with a delegation agreement filed with the Board;

(ii) The alternate supervising physician supervises no more than four physician assistants at any one time, except in a hospital, correctional facility, detention center, or public health facility;

(iii) The alternate supervising physician's period of supervision, in the absence of the primary supervising physician, does not exceed:

1. The period of time specified in the delegation agreement; and

2. A period of 45 consecutive days at any one time; and

(iv) The physician assistant performs only those medical acts that:

1. Have been delegated under the delegation agreement filed with the Board; and

2. Are within the scope of practice of the primary supervising physician and alternate supervising physician.

(k) **SUBJECT TO THE NOTICE REQUIRED UNDER § 15–103 OF THIS TITLE, A PHYSICIAN ASSISTANT MAY TERMINATE A DELEGATION AGREEMENT FILED WITH THE BOARD UNDER THIS SUBTITLE AT ANY TIME.**

(L) (1) In the event of a sudden departure, incapacity, or death of a primary supervising physician, **OR CHANGE IN LICENSE STATUS THAT RESULTS IN THE PRIMARY SUPERVISING PHYSICIAN BEING UNABLE TO LEGALLY PRACTICE MEDICINE,** a designated alternate supervising physician may assume the role of the primary supervising physician by submitting a new delegation agreement to the Board within 15 days.

(2) THE BOARD MAY TERMINATE A DELEGATION AGREEMENT IF:

(I) THE PHYSICIAN ASSISTANT HAS A CHANGE IN LICENSE STATUS THAT RESULTS IN THE PHYSICIAN ASSISTANT BEING UNABLE TO LEGALLY PRACTICE AS A PHYSICIAN ASSISTANT; OR

(II) THE SUPERVISING PHYSICIAN HAS A CHANGE IN LICENSE STATUS THAT RESULTS IN THE PHYSICIAN BEING UNABLE TO LEGALLY PRACTICE MEDICINE AND AN ALTERNATE SUPERVISING PHYSICIAN DOES NOT ASSUME THE ROLE OF SUPERVISING PHYSICIAN UNDER PARAGRAPH (1) OF THIS SUBSECTION.

[(l)**] (M)** Individual members of the Board are not civilly liable for actions regarding the approval, modification, or disapproval of a delegation agreement described in this section.

[(m)**] (N)** A physician assistant may practice in accordance with a delegation agreement filed with the Board under this subtitle.

15–302.1.

(a) If a delegation agreement does not include advanced duties or the advanced duties have been approved under § 15–302(c)(1) of this subtitle, a physician assistant may assume the duties under a delegation agreement on the date **[**of**]** **THAT THE BOARD ACKNOWLEDGES** receipt **[**by the Board**]** of the **COMPLETED** delegation agreement.

(b) In this section, "pending" means that a delegation agreement that includes delegation of advanced duties in a setting that does not meet the requirements under § 15–302(c)(1) of this subtitle has been executed and submitted to the Board for its approval, but:

(1) The Committee has not made a recommendation to the Board; or

(2) The Board has not made a final decision regarding the delegation agreement.

(c) Subject to subsection (d) of this section, if a delegation agreement is pending, on receipt of a temporary practice letter from the staff of the Board, a physician assistant may perform the advanced duty if:

(1) The primary supervising physician has been previously approved to supervise one or more physician assistants in the performance of the advanced duty; and

(2) The physician assistant has been previously approved by the Board to perform the advanced duty.

(d) If the Committee recommends a denial of the pending delegation agreement or the Board denies the pending delegation agreement, on notice to the primary supervising physician and the physician assistant, the physician assistant may no longer perform the

advanced duty that has not received the approval of the Board.

(e) The Board may disapprove any delegation agreement if it believes that:

(1) The agreement does not meet the requirements of this subtitle; or

(2) The physician assistant is unable to perform safely the delegated duties.

(f) If the Board disapproves a delegation agreement or the delegation of any function under an agreement, the Board shall provide the primary supervising physician and the physician assistant with written notice of the disapproval.

(g) A physician assistant who receives notice that the Board has disapproved a delegation agreement or an advanced function under the delegation agreement shall immediately cease to practice under the agreement or to perform the disapproved function.

15–303.

(a) To qualify for a license, an applicant shall:

(1) **[**Submit to**]** **COMPLETE** a criminal history records check in accordance with § 14–308.1 of this article;

15–304.

An applicant for a license shall:

(1) **[**Submit to**]** **COMPLETE** a criminal history records check in accordance with § 14–308.1 of this article;

15–307.

(a) (1) Unless a license is renewed for an additional term as provided in this section, the license expires on the date set by the Board.

(2) **[**A**]** **THE TERM OF A** license **ISSUED BY THE BOARD** may not **[**be renewed for a term longer than 2**]** **EXCEED 3** years.

(g) (1) Beginning October 1, 2016, the Board shall require a criminal history records check in accordance with § 14–308.1 of this article for:

(i) **[**Annual renewal**]** **RENEWAL** applicants as determined by regulations adopted by the Board; and

(ii) Each former licensee who files for reinstatement under this title.

15–308.

(b) A disciplinary panel may not reinstate a **[**suspended**]** **SURRENDERED** or revoked license that has been **[**suspended**]** **SURRENDERED** or revoked for a period of more than 1 year unless the licensee:

(1) Meets the requirements for reinstatement as established under this title; and

(2) **[**Submits to**]** **COMPLETES** a criminal history records check in accordance with § 14–308.1 of this article.

15–311.

Subject to the hearing provisions of § 15–315 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of a quorum, may deny a license to any applicant for:

(1) Any of the reasons that are grounds for disciplinary action under § 15–314 of this subtitle; and

(2) Failure to **[**submit to**]** **COMPLETE** a criminal history records check in accordance with § 14–308.1 of this article.

15–314.

(a) Subject to the hearing provisions of § 15–315 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum, may reprimand any physician assistant, place any physician assistant on probation, or suspend or revoke a license if the physician assistant:

(42) Performs delegated medical acts without the supervision of a physician; **[**or**]**

(43) Fails to **[**submit to**]** **COMPLETE** a criminal history records check under § 14–308.1 of this article**;**

(44) FAILS TO COMPLY WITH THE REQUIREMENTS OF THE PRESCRIPTION DRUG MONITORING PROGRAM UNDER TITLE 21, SUBTITLE 2A OF THIS ARTICLE; OR

(45) FAILS TO COMPLY WITH ANY STATE OR FEDERAL LAW PERTAINING TO THE PRACTICE AS A PHYSICIAN ASSISTANT.

15–315.

(a) (1) Except as otherwise provided under § 10–226 of the State Government Article, before a disciplinary panel takes any action under § 15–311 or § 15–314(a) of this subtitle, the disciplinary panel shall give the individual against whom the action is contemplated an opportunity for a hearing before a hearing officer.

(2) The hearing officer shall give notice and hold the hearing in accordance with Title 10, Subtitle 2 of the State Government Article.

(3) A disciplinary panel may administer oaths in connection with any proceeding under this section.

[(4) At least 14 days before the hearing, the hearing notice required under this subtitle shall be sent by certified mail to the last known address of the individual.**]**

15–316.

(a) If, after a hearing under § 15–315 of this subtitle, a disciplinary panel finds that there are grounds for discipline under § 15–314(a) of this subtitle to suspend or revoke a license of a physician assistant **[**or to**],** reprimand a licensed physician assistant, **OR PLACE THE LICENSED PHYSICIAN ASSISTANT ON PROBATION,** the disciplinary panel may impose a fine subject to the Board's regulations **[**instead of or**]** in addition to suspending or revoking the license **[**or**],** reprimanding the licensee**, OR PLACING THE**

LICENSEE ON PROBATION.

(C) IN ADDITION TO ANY SANCTION AUTHORIZED UNDER THIS SUBTITLE, A DISCIPLINARY PANEL MAY REQUIRE A LICENSEE TO COMPLY WITH SPECIFIED TERMS AND CONDITIONS DETERMINED BY THE DISCIPLINARY PANEL.

15–403.

(b) (1) In addition to the penalties under subsection (a) of this section, a person who violates § 15–401 of this subtitle may be subject to a civil penalty assessed by **[**the Board**]** **A DISCIPLINARY PANEL** in an amount not exceeding $5,000.

(2) In addition to the penalties under paragraph (1) of this subsection, a person who violates § 15–309 of this title may be subject to a civil penalty assessed by **[**the Board**]** **A DISCIPLINARY PANEL** in an amount not exceeding $100.

(3) The Board shall pay any civil penalty collected under this subsection into the Board of Physicians Fund.

15–502.

Subject to the evaluation and reestablishment provisions of the Maryland Program Evaluation Act, this title and all regulations adopted under this title shall terminate and be of no effect after July 1, **[**2023**]** **2030**.

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article – Health Occupations

14–404.

(a) Subject to the hearing provisions of § 14–405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

(43) Fails to comply with § 1–223 of this article; **[**or**]**

(44) VIOLATES ANY PROVISION OF THIS TITLE, ANY RULE OR REGULATION ADOPTED BY THE BOARD, OR ANY STATE OR FEDERAL LAW PERTAINING TO THE PRACTICE OF MEDICINE; OR

[(44)**] (45)** Fails to comply with the requirements of the Prescription Drug Monitoring Program under Title 21, Subtitle 2A of this article.

SECTION 3. AND BE IT FURTHER ENACTED, That, in the annual report the State Board of Physicians is required to submit under § 14–205.1 of the Health Occupations Article, as enacted by Section 1 of this Act, on or before October 1, 2020, the Board shall include:

(1) a description of the study conducted by the Board in consultation with the Polysomnography Professional Standards Committee and the Respiratory Care Professional Standards Committee on the powers and duties of the Polysomnography Professional Standards Committee; and

(2) make recommendations on whether to alter the duties of the Polysomnography Professional Standards Committee or combine the Polysomnography Professional Standards Committee with the Respiratory Care Professional Standards Committee or another allied health advisory committee.

SECTION 4. AND BE IT FURTHER ENACTED, That, in the annual report the State Board of Physicians is required to submit under § 14–205.1 of the Health Occupations Article, as enacted by Section 1 of this Act, on or before October 1, 2021, the Board shall include:

(1) an update on licensing by reciprocity and through the Interstate Medical Licensure Compact; and

(2) recommendations on whether to continue either or both methods of licensure and whether any statutory changes are needed to accomplish the goal of streamlining licensure for out–of–state physicians.

SECTION 5. AND BE IT FURTHER ENACTED, That Section 2 of this Act shall take effect on the taking effect of the termination provision specified in Section 5 of Chapter 470 of the Acts of the General Assembly of 2018. If that termination provision does not take

effect, Section 2 of this Act, with no further action required by the General Assembly, shall be abrogated and of no further force and effect. This Act may not be interpreted to have any effect on that termination provision.

SECTION 6. AND BE IT FURTHER ENACTED, That, subject to the provisions of Section 5 of this Act, this Act is an emergency measure, is necessary for the immediate preservation of the public health or safety, has been passed by a yea and nay vote supported by three–fifths of all the members elected to each of the two Houses of the General Assembly, and shall take effect from the date it is enacted.

Appendix 2.
Summary of Recommendations and Outcomes from the 2016 Sunset Review: Evaluation of the State Board of Physicians and Allied Health Advisory Committees

Recommendation	Change Type	Status	Comment
1. The board should work to improve the administrative process for issuing licenses promptly, especially for allied health professionals, and report on efforts to meet the 10-day goal in a follow-up report to the General Assembly.	Administrative	Adopted	
2. MBP should amend its regulations and update its website to accurately reflect current fees.	Administrative	Adopted	
3. The board should reestablish a late renewal process that would be available to physicians for a 60-day period after the license expiration date rather than requiring them to use the reinstatement process. Statute should be amended to clarify that a physician has 60 days after the license expiration date in order to renew the license.	Regulatory	Rejected	
4. Statute should be amended to require MBP to submit an annual report on the results of CHRCs and related implementation. Specifically, MBP should be required to report the following information for physicians and allied health professionals: (1) the number of initial and renewal licenses issued; (2) the number of positive and negative CHRC results received; (3) the number of individuals denied initial or renewal licensure due to positive CHRC results; and (4) the number of individuals denied licensure due to reasons other than a positive CHRC. Further, MBP should include in the fiscal 2019 CHRC report information regarding whether CHRCs are causing licensure delays, whether existing staff are able to manage the CHRC workload, and any other concerns with the CHRC process.	Statutory	Adopted	

Recommendation	Change Type	Status	Comment
5. Given MBP's concerns about the timing of receipt and investigation of CHRC results on the renewal process, statute should be amended to clarify that the listed factors are to be considered by the board when determining whether to take disciplinary action based on the results of CHRCs against a licensee who renewed or reinstated the license.	Statutory	Adopted	
6. The board, in consultation with the Physician Assistant Advisory Committee, should study ways to expedite the process for PAs to assume the duties under a delegation agreement and report their findings and recommendations in a follow-up report.	Administrative	Adopted	The board did not recommend any changes to the processing of PA delegation agreements.
7. The board should ensure that the sexual misconduct regulations are referenced in the order summaries in cases where the licensee was specifically found to have violated them. Additionally, the board should comment in a follow-up report on the feasibility of describing the underlying sexual misconduct in order summaries or other steps that the board can take to make it easier for the public to determine whether a case involved sexual misconduct.	Administrative/ Regulatory	Adopted	
8. Statute should be amended to require that sexual misconduct reports specify for each health occupations board (1) the total number of sexual misconduct complaints received; (2) the number of practitioners and complainants involved in the complaints; (3) the number of complaints still under investigation; (4) the number of complaints that were closed with no disciplinary action; (5) the number of complaints that resulted in informal or nonpublic action; (6) the number of complaints resulting in denials of licensure, reprimands, probations, suspensions, and revocations; (7) the number of complaints that were referred to the Office of the Attorney General for prosecutorial action; (8) the number of complaints that were forwarded to law enforcement for possible criminal prosecution; and (9) if other actions were taken, a detailed breakdown of the types of action.	Statutory	Adopted	

Recommendation	Change Type	Status	Comment
9. The next sunset evaluation of MBP should examine the desirability of shifting proceedings involving the unauthorized practice of medicine, denials of initial licenses, certain denials of renewals or reinstatements, and cease and desist orders from the full board to the disciplinary panels.	Statutory	Rejected	
10. Statute should be amended to clarify that the panel must refer a complaint for peer review if the panel decides, after reviewing the results of the preliminary investigation, that the licensee may have committed a standard of care violation.	Statutory	Adopted	
11. Statute should be amended to require that complaints against naturopathic doctors be handled in the same manner as complaints against other allied health professionals.	Statutory	Adopted	
12. Statute should be amended to (1) distinguish between individuals who are truly excepted from licensure and UMPs and (2) explicitly allow the board to discipline UMPs in the same manner that applicants for licensure and licensees are disciplined.	Statutory	Rejected	This is no longer applicable as UMPs are no longer regulated by the board.
13. Statute should be amended to repeal the six-month mandated reporting requirement.	Statutory	Adopted	
14. Chapter 539 of 2007 should be amended to repeal the requirement that the Chief Administrative Law Judge designate a pool of ALJs to hear cases referred by MBP. Conversely, the requirement in Chapter 539 that MBP provide annual training to OAH should be codified. Also, MBP and OAH should update each other, as necessary, regarding developments and changes in procedures that affect the other entity and the efficiency of the complaint process.	Administrative/ Statutory	Adopted	

Recommendation	Change Type	Status	Comment
15. The board should report revenues and expenditures by practitioner type in its annual reports required under § 14-205 of the Health Occupations Article, beginning with the fiscal 2017 annual report. Further, in fiscal 2018, the board should conduct an internal fiscal analysis and reassess its fee schedules. The board should submit a follow-up report to DLS by October 1, 2018, with the results of the internal fiscal analysis, including any possible changes to the board's fee schedules for physicians and allied health professionals. The board should specifically comment on the board's fund balance in light of the additional retained revenue from the MLARP and HPSIG changes, as well as the ongoing issue of filling staff vacancies and the impact of filling these vacancies on the board's expenditures and fund balance.	Statutory	Modified	The fiscal analysis portion of this recommendation was shifted to the board's fiscal 2019 report.
16. To enhance compliance with the Open Meetings Act, if the board or a disciplinary panel begins to discuss a matter in closed session that violates the Act, board counsel should advise the board or disciplinary panel that it is violating the Act, and the board or disciplinary panel should cease discussion. Also, the board or disciplinary panel should state other statutory exceptions for closing a meeting in the written statement when nondisciplinary items are on the agenda.	Administrative	Adopted	
17. To enhance public transparency, all documents and website information should clearly label all meetings in which the full board meets, either in person or through conference call, as meetings of the full board, rather than as meetings of a disciplinary panel.	Administrative	Adopted	
18. Statute should be amended to allow health occupations boards that have jurisdiction over authorized prescribers who have entered into a prescriber-pharmacist agreement to enter into an agreement with the State Board of Pharmacy to require that the authorized prescribers submit the agreement and any subsequent modifications to the agreement to the State Board of Pharmacy.	Statutory	Adopted	The board clarified that this recommendation applies to the Pharmacy Board's statute.

Recommendation	Change Type	Status	Comment
19. Statute should be amended to extend the termination date for the State Board of Physicians and the related allied health advisory committees until July 1, 2023. Further, uncodified language should be adopted to limit the scope of the next sunset evaluation to evaluating (1) the implementation of recommendations made in this report; (2) the efficacy of the two-panel disciplinary system; and (3) the impact of criminal history records checks on the board and licensees. Uncodified language should be adopted to require that the board include in the follow-up report required to be submitted on or before October 1, 2017, under Chapter 401 of 2013, any issues specifically noted in this report for inclusion in a subsequent follow-up report, except for fiscal issues. Finally, uncodified language should be adopted in the 2017 session of the General Assembly to require that the board include in the follow-up report required to be submitted on or before October 1, 2018, under Chapter 401 of 2013, any fiscal issues specifically noted in this report for inclusion in a subsequent follow-up report.	Statutory	Adopted	

ALJ: administrative law judge
CHRC: criminal history records check
DLS: Department of Legislative Services
HPSIG: Health Personnel Shortage Incentive Grant
MLARP: Maryland Loan Assistance Repayment Program
MBP: Maryland Board of Physicians
OAH: Office of Administrative Hearings
PA: physician assistant
UMP: unlicensed medical practitioner

Source: State Board of Physicians; Department of Legislative Services

Appendix 3.
Physician Initial and Renewal License Fees by State

State	Initial License	Renewal License	Renewal Interval (Years)
Alabama	$175	$300	1
Alaska	500	300	2
Arizona[1]	500	500	2
Arkansas	500	220	1
California[1]	1,262	820	2
Colorado	412	238	2
Connecticut	569.75	575	1
Delaware	378	378	2
District of Columbia	805	500	2
Florida[1]	429	391	2
Georgia	500	230	2
Hawaii	221	402	2
Idaho	500	250	1
Illinois	700	700	3
Indiana	250	200	2
Iowa	450	450	2
Kansas	300	300	1
Kentucky	300	150	1
Louisiana	382	330	1
Maine[1]	700	500	2
Maryland	790	512	2
Massachusetts	600	600	2
Michigan[1]	156	156	3
Minnesota	392	192	1
Mississippi	550	200	1
Missouri	75	100	1
Montana	500	500	2
Nebraska	300	121	2
Nevada[1]	1,050	750	2
New Hampshire	300	350	2
New Jersey	805	580	2
New Mexico[1]	400	600	3
New York	735	600	2
North Carolina	400	250	1

State	Initial License	Renewal License	Renewal Interval (Years)
North Dakota	$205	$205	1
Ohio	305	305	2
Oklahoma[1]	500	200	1
Oregon	486	375	2
Pennsylvania[1]	35	360	2
Rhode Island	1,090	1,090	2
South Carolina	580	155	2
South Dakota	400	400	2
Tennessee[1]	410	235	2
Texas	817	464	2
Utah[1]	200	183	2
Vermont[1]	650	525	2
Virginia	302	270	2
Washington[1]	491	657	2
West Virginia[1]	400	400	2
Wisconsin	75	141	2
Wyoming	600	250	1

[1] State has separate medical boards for medical doctors and osteopaths.

Note: Alaska's board also regulates podiatrists. California's fee reflects a $442 application fee, $783 licensure fee, $12 Prescription Drug Monitoring Program fee, and $25 loan repayment fund fee. Hawaii's initial license fee is $392 if issued in an even-numbered year to pay for partial renewal fee. Iowa's renewal fee is $550 if done on paper (as opposed to online).

Source: Federation of State Medical Boards, *U.S. Medical Regulatory Trends and Actions 2018*

Appendix 4.
Medical Board Membership by State

State	Number of Board Members	Allied Health Members	Consumer Members	Notes
Alabama	16	0	0	
Alaska	8	1	2	Also regulates podiatrists.
Arizona	12	1	3	Separate medical boards for medical doctors (MDs) and osteopaths.
Arkansas	14	0	2	
California	15	0	7	Separate medical boards for MDs and osteopaths.
Colorado	16	1	4	
Connecticut	21	1	7	
Delaware	16	0	5	
District of Columbia	15	0	4	
Florida	15	0	3	Separate medical boards for MDs and osteopaths.
Georgia	16	1	2	
Hawaii	11	0	2	
Idaho	10	0	2	
Illinois	7	1	0	Regulates chiropractors.
Indiana	7	0	1	
Iowa	10	0	3	
Kansas	15	0	3	
Kentucky	15	0	3	
Louisiana	7	0	0	
Maine	10	1	3	Separate medical boards for MDs and osteopaths.
Maryland	22	1	6	
Massachusetts	7	0	2	
Michigan	19	1	8	Separate medical boards for MDs and osteopaths.
Minnesota	16	0	5	
Mississippi	9	0	3	
Missouri	9	0	1	
Montana	13	5	2	
Nebraska	8	0	2	

State	Number of Board Members	Allied Health Members	Consumer Members	Notes
Nevada	9	0	3	Separate medical boards for MDs and osteopaths.
New Hampshire	11	1	3	
New Jersey	21	2	3	
New Mexico	9	1	2	Separate medical boards for MDs and osteopaths.
New York	24	2	2	
North Carolina	13	2	3	
North Dakota	13	1	2	
Ohio	12	1	3	
Oklahoma	9	0	2	Separate medical boards for MDs and osteopaths.
Oregon	13	1	2	
Pennsylvania	11	1	2	Separate medical boards for MDs and osteopaths.
Rhode Island	13	0	6	
South Carolina	13	0	3	
South Dakota	9	0	2	
Tennessee	12	0	3	Separate medical boards for MDs and osteopaths.
Texas	19	0	7	
Utah	11	0	2	Separate medical boards for MDs and osteopaths.
Vermont	17	2	6	Separate medical boards for MDs and osteopaths.
Virginia	18	0	4	
Washington	21	0	6	Separate medical boards for MDs and osteopaths.
West Virginia	16	4	3	Separate medical boards for MDs and osteopaths.
Wisconsin	13	0	3	Five affiliated boards, four councils.
Wyoming	8	1	2	

Source: Federation of State Medical Boards, *U.S. Medical Regulatory Trends and Actions 2018*

Appendix 5.
Summary of the Responses to the Department of Legislative Services Survey of Individuals Regulated by the State Board of Physicians

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The Department of Legislative Services (DLS) of the Maryland General Assembly is evaluating the State Board of Physicians (board). As part of this evaluation, DLS is conducting a survey to gather feedback from individuals regulated by the board.

The survey primarily consists of multiple choice questions and, unless you wish to expound on your answers, generally should take no more than 10 minutes to complete. Your responses will not be attributed to you by name, and the completed surveys will not be shared with the board or any other State agency. This survey is predominantly focused on your interactions with the board in the past three years.

Please complete the survey by August 23, 2019. If you have any questions, please contact Andrew Garrison or Lindsay Rowe, Policy Analysts with DLS, at (410) 946-5350 or (301) 970-5350.

Thank you in advance for your time and assistance.

1. In your opinion, Maryland State laws and regulations governing physicians are:

Answered 3,356
Skipped 0

Answer Options		Responses
Insufficient	0.92%	31
Somewhat insufficient	2.83%	95
Reasonable	71.84%	2,411
Somewhat excessive	17.55%	589
Excessive	6.85%	230
Additional comments regarding the laws and regulations in Maryland for physicians:		285

2. In your opinion, Maryland State laws and regulations governing allied health professionals are:

Answered 3,356
Skipped 0

Answer Options		Responses
Insufficient	4.65%	156
Somewhat insufficient	10.79%	362
Reasonable	67.52%	2,266
Somewhat excessive	12.13%	407
Excessive	4.92%	165
Additional comments regarding the laws and regulations in Maryland for allied health professions:		324

3. Have you ever interacted with the board's allied health advisory committee for your profession?

Answered 3,356
Skipped 0

Answer Options		Responses
Yes	10.49%	352
No	53.81%	1,806
Not applicable (I am a physician)	35.70%	1,198

4. Based on your experience with your allied health advisory committee, please indicate your level of agreement with the following statements:

Answered 1,823
Skipped 1,533

	Strongly Agree		Agree		Somewhat Agree		Somewhat Disagree		Disagree		Strongly Disagree		Total
I am familiar with the function and processes of my profession's advisory committee.	5.20%	94	25.98%	470	29.96%	542	13.60%	246	16.80%	304	8.46%	153	1,809
I believe my profession is adequately represented by my profession's advisory committee.	3.74%	66	28.73%	507	33.20%	586	17.22%	304	10.25%	181	6.86%	121	1,765
I believe that my profession should continue to be regulated and licensed by the board.	22.65%	407	45.80%	823	18.92%	340	5.40%	97	3.62%	65	3.62%	65	1,797

Additional comments regarding your profession's allied health advisory committee: 157

5. As a physician, I have interacted with the following allied health advisory committees (select all that apply):

Answered 1,080
Skipped 2,276

Answer Options		Responses
Athletic Trainers Advisory Committee	0.56%	6
Naturopathic Medicine Advisory Committee	0.46%	5
Physician Assistant Advisory Committee	3.89%	42
Polysomnography Professional Advisory Committee	0.28%	3
Radiation Therapy, Radiography, Nuclear Medicine Technology, and Radiologist Assistance Advisory Committee	1.11%	12
Perfusion Advisory Committee	0.28%	3
Respiratory Care Professional Standards Committee	0.46%	5
I do not interact with any allied health advisory committee.	95.28%	1,029

6. Based on your experience as a physician, please indicate the level of regulation you believe is adequate for the following allied health professionals:

Answered 1,085
Skipped 2,271

	Should Continue to Be Regulated By the Board		Should Be Regulated in Maryland Separately From the Board		Do Not Need to Be Regulated by Maryland		Do Not Know/ No Opinion		Total
Athletic Trainers	39.63%	426	20.74%	223	7.81%	84	31.81%	342	1,075
Naturopathic Doctors	65.61%	706	14.03%	151	2.42%	26	17.94%	193	1,076
Physician Assistants	82.68%	888	5.68%	61	0.74%	8	10.89%	117	1,074
Polysomnographers	50.98%	548	16.93%	182	3.63%	39	28.47%	306	1,075
Radiation Therapists, Radiographer, Nuclear Medicine Technologists, and Radiologist Assistants	65.86%	712	15.63%	169	1.20%	13	17.30%	187	1,081
Perfusionists	59.80%	644	15.69%	169	2.23%	24	22.28%	240	1,077
Respiratory Care Practitioners	64.07%	690	16.53%	178	1.58%	17	17.83%	192	1,077

Additional comments regarding the board's regulation of allied health professionals: 81

7. How has the regulation of allied health professionals impacted your medical practice?

Answered 1,061
Skipped 2,295

Answer Options		Responses
The regulation of allied health professionals has enhanced my ability to practice medicine.	17.72%	188
The regulation of allied health professionals has not impacted my ability to practice medicine.	72.67%	771
The regulation of allied health professionals has hindered my ability to practice medicine.	9.33%	99
If the regulation of allied health professionals has significantly impacted your ability to practice medicine, please elaborate below:		79

8. Based on your personal experience in the past three years, please indicate your level of agreement with the following statements regarding board members and staff:

Answered 2,855
Skipped 501

	Strongly Agree		Agree		Somewhat Agree		Somewhat Disagree		Disagree		Strongly Disagree		Do Not Know		Total
Board members and staff are professional.	11.98%	342	32.82%	937	9.56%	273	2.87%	82	2.10%	60	2.42%	69	38.25%	1,092	2,855
Board members and staff communicate.	7.99%	228	25.67%	733	16.08%	459	5.46%	156	4.83%	138	4.03%	115	35.94%	1,026	2,855
Board members and staff are impartial/unbiased.	8.58%	245	24.55%	701	10.09%	288	4.31%	123	3.22%	92	3.92%	112	45.32%	1,294	2,855
The board keeps regulated professionals adequately informed regarding changes in laws and regulations.	10.68%	305	36.46%	1,041	18.95%	541	6.90%	197	6.27%	179	3.68%	105	17.06%	487	2,855
Board staff respond to questions in a timely manner.	7.64%	218	21.47%	613	12.78%	365	4.94%	141	4.13%	118	4.45%	127	44.59%	1,273	2,855
Board staff provide clear and helpful responses to my inquiries.	8.09%	231	21.12%	603	12.36%	353	4.62%	132	4.20%	120	4.62%	132	44.97%	1,284	2,855

Additional comments regarding board members and staff: 215

9. Based on your personal experience in the past three years, please indicate your level of agreement with the following statements regarding board performance:

Answered 2,760

Skipped 596

	Strongly Agree		Agree		Somewhat Agree		Somewhat Disagree		Disagree		Strongly Disagree		Do Not Know		Total
The board enforces laws/regulations uniformly/fairly.	7.90%	218	32.21%	889	11.27%	311	3.01%	83	3.70%	102	3.01%	83	38.91%	1,074	2,760
The board handles disciplinary actions uniformly /fairly.	6.70%	185	27.64%	763	10.07%	278	3.44%	95	2.79%	77	3.48%	96	45.87%	1,266	2,760
The board provides clear instructions on how to apply for and/or renew a license.	25.69%	709	45.94%	1,268	12.54%	346	4.24%	117	2.10%	58	2.10%	58	7.39%	204	2,760
The board issues new licenses within a reasonable timeframe.	18.77%	518	38.22%	1,055	9.60%	265	4.64%	128	3.62%	100	4.71%	130	20.43%	564	2,760
The board renews existing licenses within a reasonable timeframe.	31.74%	876	45.76%	1,263	9.64%	266	1.56%	43	1.49%	41	1.20%	33	8.62%	238	2,760
Complaints are handled in a timely manner.	4.86%	134	16.49%	455	8.44%	233	2.90%	80	3.37%	93	2.90%	80	61.05%	1,685	2,76
The investigative process is fair and objective.	5.91%	163	17.43%	481	7.32%	202	3.19%	88	2.61%	72	4.38%	121	59.17%	1,633	2,760

Additional comments regarding the board's performance: 174

10. In the past three years, have you requested assistance from the board with a licensing or disciplinary issue due to special circumstances (*e.g.*, certifying foreign medical education, expediting a license, qualifying alternative education, licensing military personnel or their spouse, converting a volunteer license to a regular license, *etc.*)?

Answered 2,760
Skipped 596

Answer Options	Responses	
Yes	6.78%	187
No	93.22%	2,573

11. Based on your personal experience making a special request of the board, please indicate your level of agreement with the following statements:

Answered 189
Skipped 3,167

	Strongly Agree		Agree		Somewhat Agree		Somewhat Disagree		Disagree		Strongly Disagree		Total
The board clearly explained any steps necessary to respond to my request(s).	17.99%	34	37.04%	70	14.29%	27	9.52%	18	11.64%	22	9.52%	18	189
I was satisfied with the board's assistance with my special request(s).	20.32%	38	26.74%	50	11.76%	22	12.83%	24	17.11%	32	11.23%	21	187

Additional comments regarding the board's treatment of special requests: 28

12. In the past three years, has the board investigated a complaint against you or taken disciplinary action against you?

Answered 2738
Skipped 618

Answer Options	Responses	
Yes	7.49%	205
No	92.51%	2533

13. Did board correspondence clearly convey the board's complaint resolution process?

Answered 191
Skipped 3,165

Answer Options		Responses
Yes	62.30%	119
No	37.70%	72
If no, please explain:		46

14. Did board correspondence clearly convey the actions required of you to resolve an investigation or disciplinary matter?

Answered 191
Skipped 3,165

Answer Options	Responses	
Yes	72.25%	138
No	27.75%	53
If no, please explain:		36

15. How did the board resolve complaint(s) against you (select all that apply)?

Answered 191
Skipped 3,165

Answer Options		Responses
Closure with No Action	53.40%	102
Advisory Letter	19.37%	37
Disciplinary Committee for Case Resolution	12.57%	24
Evidentiary Hearing/Final Order	9.42%	18
Other (please specify)	14.14%	27

16. Please select which level of disciplinary action(s) you received from the board (Select all that apply):

Answered 191
Skipped 3,165

Answer Options		Responses
Dismissed	44.50%	85
Advisory Letter	21.99%	42
Fine	7.85%	15
Reprimand	12.57%	24
Probation	10.47%	20
License Suspended	2.09%	4
License Surrendered	0.52%	1
License Revoked	1.05%	2
Action Still Pending	9.42%	18
Other (please specify)	10.99%	21

17. Based on your experience with the board, please indicate your level of agreement with the following statements regarding the disciplinary process:

Answered 191
Skipped 3,165

	Strongly Agree		Agree		Somewhat Agree		Somewhat Disagree		Disagree		Strongly Disagree		Total
The board's disciplinary process was fair.	17.80%	34	25.65%	49	12.04%	23	9.95%	19	12.57%	24	21.99%	42	191
The board clearly described the specific action(s) or behavior(s) that constituted a violation(s).	15.71%	30	29.84%	57	16.23%	31	10.47%	20	12.04%	23	15.71%	30	191
The board adjudicated my case(s) in a timely manner.	16.23%	31	25.13%	48	18.85%	36	6.28%	12	9.95%	19	23.56%	45	191
Public information listed on the board's website (*i.e.,* board actions, practitioner profile) accurately reflects the facts of any disciplinary actions or charges against me.	17.28%	33	32.46%	62	12.57%	24	9.95%	19	10.99%	21	16.75%	32	191

Additional comments regarding the board's complaint resolution and disciplinary processes: 53

18. Based on your most recent interaction(s) with the board and staff, compared to interactions prior to 2016, please indicate the areas in which you believe performance has improved (select all that apply):

Answered 2,501
Skipped 855

Answer Options	Responses	
Fairness of the complaint resolution/disciplinary processes.	7.12%	178
Timeliness of the complaint resolution/disciplinary processes.	6.16%	154
Professionalism.	15.67%	392
Clarity on how to have a license issued or renewed.	37.23%	931
Timeliness of issuing or renewing licenses.	34.99%	875
Responsiveness.	15.55%	389
No noticeable change.	30.51%	763
Please provide additional comments on the improvements you have noticed:	419	

19. Based on your most recent interaction(s) with the board and staff, compared to interactions prior to 2016, please indicate the areas in which you believe performance has deteriorated (select all that apply):

Answered 2,501
Skipped 855

Answer Options		Responses
Fairness of the complaint resolution/disciplinary processes.	10.00%	250
Timeliness of the complaint resolution/disciplinary processes.	9.88%	247
Professionalism.	12.08%	302
Clarity on how to have a license issued or renewed of licenses.	17.03%	426
Timeliness of issuing or renewing licenses.	15.67%	392
Responsiveness.	20.23%	506
No noticeable change.	39.94%	999
Please provide additional comments on areas of deterioration you have noticed:	632	

20. Please indicate which license(s) you currently hold:

Answered 2,465
Skipped 891

Answer Options		Responses
Physician	68.76%	1,695
Athletic Trainer	4.71%	116
Naturopathic Doctor	0.12%	3
Perfusionist	0.37%	9
Physician Assistant	7.75%	191
Polysomnographer	0.49%	12
Radiation Therapist/Radiographer/Nuclear Medicine Technologist/Radiologist Assistant	11.81%	291
Respiratory Care Practitioner	5.52%	136
Other (please specify)	1.22%	30

21. In which Maryland jurisdiction do you primarily work?

Answered 2,364
Skipped 992

Answer Options		Responses
I do not practice regularly in Maryland.	14.72%	348
Allegany County	1.23%	29
Anne Arundel County	6.51%	154
Baltimore City	21.19%	501
Baltimore County	14.21%	336
Calvert County	0.68%	16
Caroline County	0.17%	4
Carroll County	1.61%	38
Cecil County	0.72%	17
Charles County	0.80%	19
Dorchester County	0.47%	11
Frederick County	2.54%	60
Garrett County	0.59%	14
Harford County	2.54%	60
Howard County	3.51%	83
Kent County	0.25%	6
Montgomery County	15.10%	357
Prince George's County	6.81%	161
Queen Anne's County	0.38%	9
Somerset County	0.42%	10
St. Mary's County	0.59%	14
Talbot County	0.68%	16
Washington County	1.78%	42
Wicomico County	1.86%	44
Worcester County	0.63%	15

22. How long have you been practicing in Maryland?

Answered	2,427
Skipped	929

Answer Options		Responses
5 years or fewer	21.76%	528
6 to 15 years	22.87%	555
16 to 25 years	19.20%	466
More than 25 years	36.18%	878

23. Do you hold a license to practice in any other state/jurisdiction?

Answered	2,448
Skipped	908

Answer Options		Responses
Yes	37.87%	927
No	62.13%	1,521

24. Please provide any additional information you would like us to consider in our evaluation of the board:

Answered	448
Skipped	2,908

December 6, 2019

Ms. Victoria L. Gruber, Director
Office of Policy Analysis
Department of Legislative Services
90 State Circle
Annapolis, MD 21401-1991

Dear Ms. Gruber:

The Maryland Board of Physicians (the "Board") recognizes the diligent work the Department of Legislative Services (DLS) analysts committed to the Board's 2019 Sunset Review. The Board would especially like to thank Ms. Lindsay A. Rowe, Mr. Andrew C. Garrison, and Ms. Jennifer B. Chasse for their thorough analysis and professional interactions with all Board representatives.

During the evaluation, Board members, leadership and staff embraced the opportunity to collaborate with DLS, conduct its own internal assessment, address inconsistencies across professions, develop strategies to enhance operational efficiency, and fix long-standing issues in statute.

The Board appreciates the opportunity to review the Exposure Draft, provide responses to the recommendations and proactively engage in the Sunset Review process before the report is finalized. Further, it appreciates DLS' consideration of the issues raised by the Board during the evaluation process.

Enclosed please find the Board's preliminary response. The Board agrees with all but two of the recommendations and has made suggestions and clarifications to several of the recommendations that would result in even greater efficiency.

In the addendum to the response, the Board, in furtherance of its overall efficacy initiatives and for consideration of enactment by the legislature, commits to drafting a general provisions section and standardized annual reporting requirements.

We look forward to continued interaction with your office during this process.

Sincerely,

Damean W. E. Freas, D.O.
Board Chair

Christine A. Farrelly
Executive Director

Enclosure

c: Robert Neall, Secretary, MDH
Webster Ye, Director, Office of Governmental Affairs, MDH
Jennifer B. Chasse, Principal Policy Analyst, DLS
Ellen D. Smith, Deputy Director, MBP
Yemisi Koya, Director, Communications and Education, MBP
Wynee Hawk, Manager, Policy and Legislation, MBP
Noreen Rubin, Board Counsel, OAG

Maryland Board of Physicians
Response to Sunset Exposure Draft

Overview: The Board agrees with Recommendations 2, 3, 5, 6, 7, 9, 15, 16, 17, 18, 19, 20, 22, 23, 24, 25, and 28 and has no further comments. The Board agrees with Recommendations 4, 8, 10, 11, 13, 14, 21, 26, and 27, but has provided comments in response. Many of these were collaborative, having been raised by the Board to the Sunset Reviewers. The Board disagrees with Recommendations 1 and 12. Further, the Board appreciates that the reports required by Recommendations 4 and 24 are limited to a one time requirement, and will align with the Board's effort to standardize the Annual Report which is discussed in the Addendum.

Recommendation 1: The board should allow a licensee to complete an online license renewal at any time during the 90 days immediately preceding license expiration.

Board Response: The Board disagrees with this recommendation for several reasons. Opening an online renewal period requires considerable preparation and entails significant coordination to ensure that numerous components of the renewal process are timely including, but not limited to, verifying tax liability, criminal history record checks ("CHRCs"), audits of continuing medical education ("CME") credits, processing and reconciling payments, and reporting of revenue.

1. The Board can only retain a CHRC for a period of 90 days in compliance with State and Federal laws. Because the Board needs time to process CHRCs, the Board recommends that applicants and licensees submit their fingerprints no earlier than 6 weeks before the date they intend to complete their application. If more than 90 days elapses, the applicant or licensee will be required to submit a whole new CHRC at an additional expense. If online renewal is opened too early, it may cause confusion and result in a licensee having to complete multiple CHRCs.

2. Renewal of licenses is a continuous cyclical process at the Board. When one group completes its renewal, another group generally begins theirs. In even numbered years, licenses expire on January 31st, March 31st, May 30th, June 30th and September 30th. In odd numbered years, licenses expire on April 30th, May 30th, June 30th and September 30th. Extending the renewal period for licensees will result in even more overlap of renewal cycles, which will create an administrative burden for the Board.

3. There is significant preparation prior to opening an online renewal. The statute (H.O. 1-213) requires that the Board verify that the licensee has paid all undisputed taxes and unemployment insurance contributions with the Comptroller's Office. If a licensee has outstanding taxes or unemployment contributions, the Board has to send a letter advising the licensee to resolve the issue with the Comptroller's Office in order to be eligible for renewal. These letters usually involve additional interactions with the licensees by telephone, email or letter. This generally occurs prior to the reminder postcard that is sent to licensees notifying them of the commencement of the online renewal period. There is also data that must be uploaded, testing of the system and other Information Technology-related tasks that need to be completed before a renewal period begins. During the renewal period for each licensee group, Board staff is required to process payments on a daily basis and reconcile the payments with the issued license renewals. Increased overlap of practitioner renewals will

further complicate these steps.

4. Online renewal opening date(s) are related to the Board's necessary revenue for each fiscal year. Modification or extension of time for online renewals may result in Board expenditures exceeding Board revenue for certain fiscal years. The length of the online renewal period is also dependent on the volume of licensees. Licensees currently already have an average of 61 days prior to the expiration to renew their license, which is more than sufficient time for a licensee to access the renewal application, which is online 24 hours a day during the entire renewal period, and can be completed up to 11:59 p.m. on the date of license expiration.

5. Each practitioner statute requires the Board to send a notice to the licensee "at least 1 month before the license expires." *See* Health Occ. 14-316(b), 14-5A-13(b), 14-5B-12(b), 14-5C-14(b), 14-5D-12(b), 14-5E-13(b), 14-5F-15(b) and 15-307(b). The discussion in the Sunset Exposure Draft stated that licensees reported receiving only one notice; however, the Board actually sends four (4) renewal notices to all licensees throughout the renewal process. Licensees are given ample notice and have more than sufficient time to complete the renewal application.

6. The Board is required to conduct audits of CME credits for each practitioner type. Generally, licensees have the two years preceding the expiration of the license to complete CMEs. During the online renewal process, individuals are selected randomly and informed that they have been selected and must send their completed CMEs to the Board for an audit. Opening the renewal period too far ahead will cause confusion among licensees and delay the audit process.

Recommendation 4: To better understand the efficacy and efficiency of licensing physicians from out-of-state, in its 2021 annual report, the board should (1) include an update on licensing by reciprocity and through the Interstate Medical Licensure Compact; and (2) make recommendations on whether to continue either or both methods of licensure and whether any statutory changes are needed to accomplish the goal of streamlining licensure for out-of-state physicians.

Board Response: The Board agrees with this recommendation, but would note that no applicants have met the requirements for licensure by reciprocity and the application process has resulted in greater inefficiency and delays in licensure.

Recommendation 8: The board should consult with the appropriate allied health advisory committees and review licensure requirements for allied health professionals to determine if requirements for national certification create opportunities to simplify the State licensing process or reduce State licensing fees for these allied health professionals.

Board Response: The Board agrees with this recommendation and has already consulted with the committees and believes further consultation is not indicated.

Board staff consulted with several committee members of the Respiratory Care Professional

Standards and Radiation Therapy, Radiography, Nuclear Medicine Technology and Radiology Assistance Advisory Committees who work in the professions. The Allied Health committee members strongly support the distinction between licensure and maintenance of certification and recommend that they continue as two separate processes. Both groups do not support practice with certification as the only requirement for licensure. All noted that a national credentialing agency would have no authority in the State of Maryland and its mission is not related to public protection. Other committees have also considered aspects of this issue such as the Polysomnography Professional Standards Committee which recently discussed whether maintenance of national certification should count towards completion of Continuing Education ("CE") credits and they rejected this as an option because the national certification is for 5-year terms and recognizes some CEs that the committee did not believe were adequate.

While the terms licensing and certification are often used interchangeably and seem duplicative, there are meaningful distinctions that ensure competence and protect patients and consumers. Licensure is the process by which the State of Maryland, through a practice act, establishes the powers of the Board, a practitioner's scope of practice, continuing education, disciplinary process, and grants a practitioner permission to practice their health occupation subject to regulation under the Board's authority.

In contrast, certification is the process by which a *private entity* recognizes practitioners for meeting certain criteria established by the organization that demonstrates advanced knowledge, training, competency and skills. A government agency such as the Board can require a certification as *part* of the licensure process as an added layer of competency and public protection, however, certification is only one component of licensure. There are other important requirements for licensure, such as good moral character, continuing education requirements, education, etc. The Board agrees with the committees that ***both*** licensure and certification are essential criteria for assuring licensure of competent practitioners in Maryland.

Recommendation 10: Statute should be amended to authorize a hospital to bring in a physician who is licensed and resides in another jurisdiction to practice medicine without a Maryland license while engaged in clinical training with a licensed physician in Maryland without the need for application to the board. For clarity, statute should be further amended to combine and reorganize the two statutory sections governing exceptions to physician licensure.

Board Response: The Board agrees with this recommendation. The Board would further recommend that the time limitation in the current language that the "demonstration of the skill or procedure take no more than 14 consecutive days within a calendar year" be amended to the "demonstration of the skill *is limited to a period of time not to exceed a total of 14 days within a calendar year*." This will prevent overutilization and any misinterpretation of this exception.

Recommendation 11: Statute should be amended to create an exception to licensure to allow a respiratory care practitioner licensed outside the State to practice respiratory care on a patient who is being transported into Maryland.

Board Response: The Board agrees with this recommendation, however, the Board would recommend the inclusion of a time limitation, such as "provided such services are not rendered for more than two calendar days in any calendar year." This will allow for licensed respiratory care practitioners from other jurisdictions to act during those rare, time-limited situations when a patient is being transferred into or out of a Maryland facility and continuity of respiratory care must be maintained during the transfer, while preventing this licensure exception from being used excessively or as a means to bypass the ordinary licensure process. This time limitation also keeps this exception consistent with licensure exceptions for other practitioners, as well as similar licensure exceptions for respiratory care practitioners in other states such as Connecticut (2 calendar days), Ohio (less than 72 hours) and North Carolina (5 hours).

Recommendation 12: Statute should be amended to allow the board to amend its regulations to increase the amount of time a respondent has to address findings in a peer review from 10 business days to 20 business days for cases of failure to meet appropriate standards of care as determined by peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State.

Board Response: The Board disagrees with this recommendation. In light of public safety concerns, increasing the response time from 10 to 20 business days would delay the investigative process, the issuance of charges and the resolution of the case.

Peer review reports identify violations of the standard of care including the over-prescribing of opioids, but the Board cannot take action to protect the public until a response is received or the time period to provide a response has passed. During this time, the physician can continue to practice and any over-prescribing of opioids or other standard of care violations will continue. Delaying the issuance of charges contradicts the mission of the Board to protect the public and can result in a danger to the public health and welfare of the citizens of Maryland. The Board remains concerned about the current delay of 10 business days that is required to wait for a response, but doubling the time for a Respondent to respond to the peer review without any documented need serves no valid purpose and only results in unnecessary additional delays in the Board's investigation.

The recommended additional length of time is excessive for submitting a response and will further delay case resolution. Twenty business days adds an estimated two months to each peer review case. Twenty business days equates to one calendar month and there could be up to an additional month delay before the assigned disciplinary panel is scheduled to meet. Given the stated concerns in the Sunset, that "…peer reviews can be particularly stressful for the licensee," adding more time to the process will only prolong that stress. The average timeframe for completion of peer reviews has increased from 72 days to 100 days in FY 18. The increase in response time to the peer reviews will only further delay the Board's investigation, which is a public protection concern.

It should be noted that after a *full evidentiary hearing at the Office of Administrative Hearings*, exceptions from licensees are due to the Board within 15 calendar days. That process is much

more complicated and contains hearing transcripts, evidence, pre-trial motions, etc. If exceptions can be completed within 15 calendar days, a response to a peer review should not require more than 10 business days. Currently, the Board's regulations allow a Respondent to provide a response within 10 business days, plus three additional days for mailing. This is in addition to the opportunity to provide a written response to the complaint and case summaries for each medical record being reviewed *prior* to the case being sent for peer review. The Board believes that 10 business days is sufficient time to respond and that the licensee has many opportunities to respond throughout the investigation and case resolution process. Given the public safety concerns and no documented problems with the current process to justify extending the time period, the Board disagrees with this recommendation.

Recommendation 13: Beginning with the fiscal 2020 annual report, the board should include the number of standard of care cases brought before the board, how many of these cases were dismissed outright or with an advisory letter, how many were sent out for peer review, and how often the peer reviewers disagreed; both entirely and partially.

Board Response: The Board agrees with recommendation; however, it believes that another study or report will not yield any information that has not already been collected and that is not already available. Peer review has been discussed in numerous Sunset Evaluations: The 2001 Sunset recommended the use of only one peer reviewer because it was observed that the system of using two reviewers adds a level of unwarranted decision uncertainty; the 2005 Sunset focused on timeliness and how long peer reviews were taking, and as a result removed MedChi from the peer review process; the 2007 Sunset had the most extensive discussion on the problems with two peer reviewers and the likelihood of disagreement. Also noted at the time, was that "Maryland provides a level of medical review of standard of care cases that is greater than in most other states." In this regard, Maryland was and continues to be an outlier.

Interestingly, *the 2007 Sunset legislation required the Board to complete the very same report that this recommendation seeks.* The 2012 Perman Report (an additional external review after the DLS 2011 Sunset Review) also evaluated the peer review process and concluded that given the Board's internal medical consultant, one peer review provided consistency and public protection while ensuring fiscal responsibility. The Perman report's rationale for one peer review was that Board statistics demonstrated that the two statutorily required peer reviewers were in agreement in the large majority of the cases. The Board agrees with the 2001 and 2007 Sunset Reviews and the Perman Report on the peer review issue and the rationale. Physicians are the only licensure category where two peer reviewers are required. No other health practitioner group regulated by the Board or **any other health occupations board in Maryland** requires two peer reviews for any disciplinary ground.

Despite repeated Sunset discussions about peer review, the recommendation to amend the process to one peer review has never been proposed in any of the draft sunset bills. It is unclear what will be gained or different with yet another study. However, if the recommendation to conduct yet another study remains, the Board requests that this reporting be limited to a one time requirement, not included in the Annual Report, rather be adopted in uncodified language since it will not be continuously reported and will become obsolete. This will align with the Board's

request to standardize the Annual Report which is discussed in the Addendum. Further, the Board does not routinely maintain these statistics; therefore, the Board requests that any such requirement begin with FY 2021.

Recommendation 14: To improve compliance with the requirement to complete a criminal history records check, the board should conduct outreach to licensees to fully communicate what is required to submit to a CHRC. Outreach should include information regarding frequent barriers to compliance, such as out-of-date information, and focus on individuals in license categories with low rates of full compliance.

Board Response: The Board agrees with this recommendation and has already conducted significant outreach on CHRCs with very good results. The Board notes the high rate of compliance, 95.6%, or 39,477 CHRCs completed out of 41,281 licensee renewals. The Board has already engaged in several outreach activities to educate licensees about the CHRC requirements. Those continuing activities include, but are not limited to, the following:

1. All renewal notices sent to licensees (4 notices for each practitioner type) contain information regarding CHRCs;
2. Posting a standing comprehensive notice on CHRCs on the Board's website;
3. Repeating the CHRC notice in the licensure applications;
4. Publishing articles regarding CHRCs in the Board's newsletters *repeatedly*. Additionally, in response to this recommendation, the Board will publish another article in the Fall issue of the 2019 newsletter; and
5. Working directly with professional associations, hospitals, group practices, individual licensees, and universities to coordinate and assist with the CHRC process.

Through these ongoing efforts, the Board has demonstrated its commitment to conducting outreach on the matter and encourages licensees to recognize and take responsibility for their obligations as a Board licensee seriously, including the requirement to update the Board with any change in addresses.

Recommendation 21: To enhance the early effectiveness of new board members and members of allied health advisory committees, board staff should ensure that new members receive a brief training session within one month of appointment, including a focus on the functionality of board-issued devices used for reviewing and accessing board-related materials

Board Response: The Board agrees with this recommendation and to that end, Board staff already provides continuous training to Board and committee members, which includes iPad use.

The Board provides new Board and allied health advisory committee members with a "Quick Reference Sheet for iPad And PDF Expert" (Quick Reference Sheet) with instructions regarding how to access and review board-related materials and to assist them with using the iPad. In addition, staff in the Board's Information Technology (IT) unit are present during

meetings and are also available outside of business hours, including weekends, to assist Board and allied health advisory committee members with technology issues. Furthermore, IT staff conduct in-person training sessions for Board and allied health advisory committee members who request individual training sessions. It should be noted that iPads are not used by all committees.

Further, in response to this recommendation, on November 22, 2019, the Board updated and formalized its processes to include training new members within one month of appointment and on November 25, 2019, uploaded the Quick Reference Sheets to the iPad for the use of all members.

Recommendation 26: Statute should be amended to make nonsubstantive corrections and codify existing board practices.

Board Response: The Board agrees with this recommendation. The Board would appreciate the opportunity to address further inconsistencies in the statutes of the practitioner types regulated by the Board through the drafting of general provisions, which is discussed further in the Addendum.

Recommendation 27: The board should continue to improve communication with licensees and the public through training and policies to ensure phone and email inquiries receive prompt responses.

Board Response: The Board agrees with this recommendation. Board staff constantly strive to provide excellent customer service and the Board will continue its efforts by providing training and continuing to implement policies aimed at achieving prompt responses.

Maryland Board of Physicians
Response to Sunset Exposure Draft

ADDENDUM

In addition to the responses provided to the recommendations contained in the Exposure Draft, in furtherance of the Board's commitment to its public protection mandate, it is providing additional information for consideration by the legislature regarding drafting a general provisions section and standardizing the Board's annual reporting requirements. The Board believes that these initiatives will reduce redundancy, eliminate inconsistencies and enhance the Board's overall efficiency.

The Board recommends the drafting of General Provisions.

As noted in the Sunset Review, there is a lack of consistency in the statutes of the practitioner types regulated by the Board. The statutory inconsistencies affect the efficiency of the Board and raise concerns of fairness among the practitioner groups. A "General Provisions" section should be created to consolidate statutory provisions that apply to all Board licensees in one section. "General Provisions" would eliminate the need to identify multiple, numerous, repetitive and potentially inconsistent provisions in each practitioner statute. This would also be beneficial if other groups are licensed through the Board in the future. Other sections that should be consistent and apply to all practitioners can be included in General Provisions including, but not limited to: definitions, change of address, scope of license/name, applications, CHRCs, etc.

The Board recommends that it, where appropriate, draft general provisions common to all practitioners in one location to improve consistency and eliminate redundancy between practitioners regulated by the Board. The draft will be submitted for consideration by the legislature.

The Board is requesting that standardized annual report requirements be included in the Sunset bill.

The Board reviewed the Annual Reporting requirements for each of the Health Occupation Boards. Many smaller Boards have no reporting requirements while some of the other larger Boards have little or no reporting requirements. The Board is recommending that all prior Annual Report language be deleted (including the uncodified language) and that the Board's Annual Reporting requirements be similar to those of the Board of Nursing. These requirements will assist the legislature by consistently tracking the work of the Board. The proposed revised language is:

§ 14-205.1. Annual reports.

On or before October 1 each year, the Board shall submit to the Governor, the Secretary, and, in accordance with § 2-1246 of the State Government Article, the General Assembly an annual report that includes the following data calculated on a fiscal year basis:

(1) Relevant disciplinary indicators, including:
(i) The number of new complaints investigated for physicians, allied health practitioners, and unlicensed individuals;
(ii) The number of complaints that remain open as of June 30th;
(iii) The average days of the Panel's complaint investigations by practitioner type;
(iv) The most common grounds for complaints;
(v) The most common sources of the complaints received;
(vi) The number of cases not completed within 18 months and the reasons for the failure to complete the cases in 18 months;
(vii) The number and types of disciplinary actions taken by the Board;

(2) For both physicians and allied health practitioners:
(i) The number of initial, renewal and reinstatement licenses issued;
(ii) The number of positive and negative criminal history records checks results received
(iii) The number of individuals denied initial or renewal licensure due to positive criminal history records checks results; and
(iv) The number of individuals denied initial or renewal licensure due to reasons other than a positive criminal history records check.