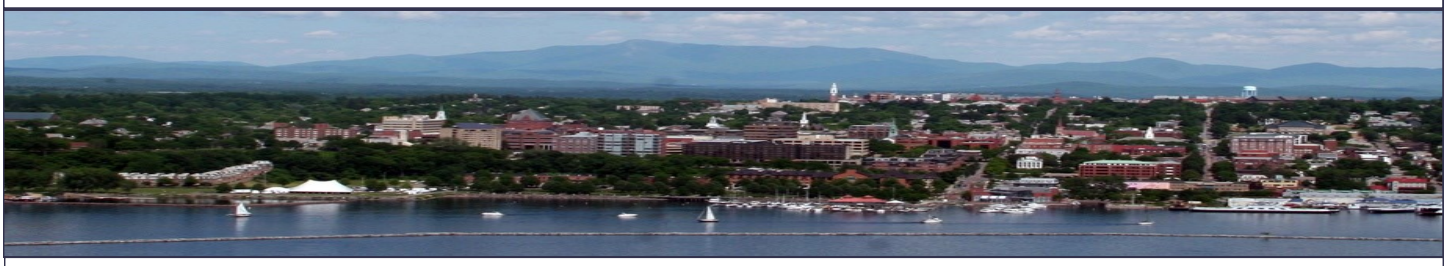
Vermont Board of Medical Practice



News from The Board

Issue 1, September 16, 2013

In this issue

Welcome to the First Issue of the "News from The Board"

On behalf of all the members and staff of the Board of Medical Practice, we are pleased to bring you this first edition of our Newsletter. It is our hope that you will find this a helpful source for information about important matters that relate to the practice of medicine, as well as a place to look for up-to-date information about licensing.

Patricia A. King MD, PhD, Board Chair

David K. Herlihy Executive Director

Our goal is to publish a new edition twice per year, or more frequently when we see a need to communicate with our licensees. Please share your thoughts with us by emailing us at **medicalboard@state.vt.us.** We would love to hear your comments and suggestions for articles.

Feature Article

Medical Marijuana: A Prescription for Confusion

Vermont's medical marijuana law was passed over ten years ago, but the Board continues to receive inquiries about it. Accordingly, we're taking this opportunity to summarize the role of the medical professional in the medical marijuana process. *Read More*

Spotlight: 2014 Renewal for Physician Assistants

It is important that you log into your account prior to the start of the renewal to update your account information.

To access your account, click here:

elicensing online system Start ▸

The 2014 renewal for Physician Assistants (PAs) will begin on October 31, 2013 and it will be available online.

Paper renewals will not be mailed out nor will they be accepted.

If you do not remember your log-on information, please contact ***Tracy Hayes*** *by phone:*

802-657-4223 *or via e-mail:* ***tracy.hayes@state.vt.us***.

VERMONT

Vermont Board of Medical Practice
PO Box 70, Burlington VT 05402-0070
802-657-4220
(within VT: 800-745-7371)
http://healthvermont.gov/hc/med_board/bmp.aspx

For more information, e-mail:
medicalboard@state.vt.us

The Vermont Prescription Monitoring System (VPMS) will launch the on-line registration system in mid-September.

An e-mail will be sent out when online registration is available.

New Prescribing Requirements

Act 75 of the 2013 General Assembly includes many provisions that affect medical professionals. Two notable requirements are:

1) Effective July 1, 2013, all prescriptions must include the date of birth of the patient. Also, all prescriptions for controlled substances that are issued on paper must show the quantity in both numeric and word form.
2) As of November 15, 2013, each prescriber who writes a prescription for controlled substances must be registered with the Vermont Prescription Monitoring System.

Medical Marijuana: A Prescription for Confusion

Vermont's medical marijuana law was passed over ten years ago, but the Board continues to receive inquiries about it. Accordingly, we're taking this opportunity to summarize the role of the medical professional in the medical marijuana process. In general, the law allows a patient whose condition meets the definition of a "debilitating medical condition" to become a registered medical marijuana user.

The law on medical marijuana does not in any way call for a medical professional to prescribe marijuana. The health care professional (M.D., D.O., P.A., or A.P.R.N.) may be asked by a patient to fill out the Health Care Professional Verification form about the patient-physician relationship and the patient's condition. The provider is asked to indicate if there has been a bona fide patient-physician relationship for at least six months, or if the patient's condition is of recent or sudden onset. The provider is also asked to choose from among stated options that characterize the patient's condition. The provider must also attest if reasonable medical efforts have been made over a reasonable amount of time without successfully relieving the symptoms. Each section of the form includes the option of indicating the patient does not meet the criterion. At no point in the form is the provider asked to provide a recommendation of whether the patient should be granted status as a registered medical marijuana user, nor is there a prescription written. The forms are available at: **http://vcic.vermont.gov/marijuana_registry/MMR%20Forms**.

What results from being designated a registered user? Patients designated as registered medical marijuana users are exempted from Vermont civil and criminal penalties so long as they do not possess in excess of the allowable amount and are not violating any of the limits on the exemption – e.g., being under the influence while operating a motor vehicle or boat, in a workplace, in a public place, on school grounds or in a correctional facility, etc. Of course, marijuana remains a Schedule I Controlled Substance and is illegal under federal law regardless of the limited exemption from prosecution under Vermont law.

The much-discussed bill of the 2013 legislative session that largely decriminalized possession of small amounts of marijuana does not make the medical marijuana law moot. Marijuana possession is still illegal in Vermont; the new law simply redefined certain marijuana violations so that they are civil violations, not misdemeanor criminal offenses.

Resources:

The medical marijuana law is available online at: **http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=18&Chapter=086**.

The Rules are online at: **http://vcic.vermont.gov/sites/vcic/files/Vermont%20Rules%202012%20v13%20Final%2005172012%20untracked.pdf**.

A list of FAQs from the program at the Department of Public Safety can be found at: **http://vcic.vermont.gov/marijuana_registry/faq**.

The Board has received a number of good questions about the provider's role and some potential dilemmas that may arise in the course of treating patients who may or may not be using medical marijuana. **The following Q&A (p. 3 & 4) are based on questions posed to the Board.**

Frequently Asked Questions

1. Could completion of the Health Care Professional Verification form endanger my DEA license?

The DEA is a federal agency and the Board cannot comment on what a federal agency would do. However, the physician's role in completing the form is only to certify facts about the relationship with the patient, the patient's health, and treatment that the patient has received. The Board is unaware of any statutes or regulations that would identify those actions as the basis for action by the DEA, but licensees may want to consult with their own legal advisors for an opinion on this issue.

2. Could completion of the Health Care Professional Verification form open me up to investigation or allegations of unprofessional conduct by the Board?

Vermont law assigns the Board the duty to investigate all complaints of unprofessional conduct against licensees. 26 V.S.A. § 1353(2). Accordingly, the Board cannot say that it would not investigate a complaint based upon a physician having completed the Health Care Professional Verification form. However, the Board would be barred by the law from disciplining a physician based only on truthful completion of the form because the medical marijuana statute provides: "(b) A health care professional who has participated in a patient's application process under subdivision 4473(b)(2) of this title shall not be subject to arrest, prosecution, or disciplinary action under 26 V.S.A. Chapter 23, penalized in any manner, or denied any right or privilege under state law, except for giving false information, pursuant to subsection 4474c(f) of this title." 18 V.S.A. § 4474b.

3. Other than what is on the form, in the statue, or the rules, is there any guidance about providers certifying a debilitating medical condition?

The Board has not issued specific guidance on this point. Licensees need to look to the statute and the rules issued by the Department of Public Safety. Links to those resources are provided on the preceding page. The definition of a debilitating condition in 18 V.S.A. § 4472 is:

> (4) "Debilitating medical condition," provided that, in the context of the specific disease or condition described in subdivision (A) or (B) of this subdivision (4), reasonable medical efforts have been made over a reasonable amount of time without success to relieve the symptoms, means:
>
> (A) cancer, multiple sclerosis, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, or the treatment of these conditions, if the disease or the treatment results in severe, persistent, and intractable symptoms; or
>
> (B) a disease, medical condition, or its treatment that is chronic, debilitating, and produces severe, persistent, and one or more of the following intractable symptoms: cachexia or wasting syndrome; severe pain; severe nausea; or seizures.

4. Part of the definition of "debilitating medical condition" under the statute is that "reasonable medical efforts have been made over a reasonable amount of time without success to relieve the symptoms." Is there guidance about what would constitute reasonable medical efforts over a reasonable period of time?

There is no more specific guidance about what would constitute a reasonable medical effort or a reasonable period of time. However, in general, Board investigations very frequently include consideration of the standard of care, and it is likely that the standard of care would be relevant to this issue. It should be expected that the Board would look to the record of care to confirm the existence of the physician-patient relationship, the documentation of the debilitating condition, and documentation of the unsuccessful treatment efforts. In any matter concerning the completion of the Health Care Professional Verification form, the physician's truthfulness in completing the form may be in issue. As discussed at Question 2, above, the statute states that a physician is not subject to discipline for completing the form, except for providing false information.

5. May a physician who does not believe in medical marijuana refuse to complete the form?

We are not aware of any statute that speaks to this issue, nor has the Board established a rule that would answer the question. In addition, there are no Board cases that provide guidance. In the absence of a decision, statute, or a rule, the Board cannot say more about how this question would be resolved. Licensees may want to consult with their own legal advisors if confronted with the issue.

6. Will physicians be able to learn if patients they are treating are registered marijuana users, in the way that they can check VPMS to obtain information about whether a patient is obtaining controlled substances from other providers?

There is no provision in law for making the names of registered marijuana users available to providers so that they could independently check to determine that.

7. Is it acceptable to prescribe opioid pain medication for a patient who uses medical marijuana?

There is no specific law or rule on point, so if the Board has a case raising the question, it will likely be an issue of whether the provider met the standard of care. The new July 2013 Federation of State Medical Boards Model Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain ("Opioid Policy") reflects the standard of care and will, in the future, influence the standard of care, so that Model Policy should be considered. The Opioid Policy does not explicitly address the issue, but use of marijuana is clearly something that must be considered by the physician who is prescribing a patient an opioid analgesic. The Opioid Policy calls for the provider to conduct a risk assessment (p. 8 – p.10), and the risk assessment includes consideration of whether the patient misuses alcohol or uses any illicit substances (while possession of small amounts of marijuana has been decriminalized under Vermont law, marijuana is still illegal under state law and marijuana is a Schedule I banned substance under federal law). The Opioid Policy also calls for the physician to have an agreement with the patient that covers the patient's responsibility to not use the opioid in combination with alcohol or other substances (p. 11). Finally, the Opioid Policy calls for the physician to make use of periodic drug testing and to address test results that reflect use of drugs that were not prescribed (p. 12 - 13). Although the medical marijuana statute offers a limited exception to the state laws making marijuana possession and use illegal, marijuana is not a prescribed drug. In sum, while there presently is no rule making it *per se* improper to prescribe opioids to a patient known to be using marijuana, at a minimum it can be said that a provider is expected to consider that a patient uses marijuana when making clinical judgments about prescribing controlled substances, to address the issue in patient agreements, and to document the clinical response to that information.

8. Is it acceptable to prescribe buprenorphine for addiction to a patient who uses medical marijuana?

The answer to this question is similar to the last answer. In the absence of any specific guideline in law or regulation, the question is really whether, in the circumstances presented, it meets the standard of care to prescribe buprenorphine to a patient who uses medical marijuana. In April 2013 the Federation of State Medical Boards published a Model Policy on the Drug Abuse Treatment Act of 2000 and Treatment of Opioid Addiction in the Medical Office ("DATA 2000 Policy"). As with the Opioid Policy, use of marijuana would be relevant to patient assessment (p. 8), establishment of a treatment agreement that addresses non-prescribed substances and drug testing for compliance (p.10), and monitoring for/ response to use of other substances (p. 11 – p. 12). As with prescribing opioids, while there presently is no rule making it per se improper to prescribe buprenorphine to a patient known to be using marijuana, at a minimum it can be said that a provider is expected to consider that a patient uses marijuana when making clinical judgments about prescribing buprenorphine, to address the issue in patient agreements, and to document the clinical response to that information.

The above is not intended to be legal advice. The Board has not taken an official position or offered official guidance on this new and evolving area of medicine. This article and the questions and answers are intended for general informational purposes only.

Serving on the Board of Medical Practice

One goal of the Board in starting to publish a newsletter is to let our licensees and the community know who we are and what it means to serve on the Board. Why do we want to get the word out? First, for our licensees, we want you to understand more about the Board that makes decisions on matters of licensing and discipline. Second, we want to inform people who may be interested in serving about what membership on the Board entails.

Like most organizations in state government, the Board's makeup and mission are set by statute. The law provides that there are 17 members – nine M.D.s, one physician assistant, one podiatrist, and six public members who have no close ties to the practice of medicine. Each member is appointed by the Governor. Terms are five years long, and the law limits its members to two consecutive full terms, not including serving a partial term to complete the term of a member who left early. All the statutes relating to the Board and oversight of physicians are found in Chapter 23 of Title 26 of the Vermont Statutes: **http://www.leg.state.vt.us/statutes/sections.cfm?Title=26&Chapter=023**.

Generally, members are asked to attend two meetings per month and to engage in preparation for the meetings. Each member is expected to attend the monthly full Board meeting, held at Gifford Hospital the first Wednesday afternoon of the month. In addition each member is assigned to an investigative committee (North, Central, or South) that meets another half day each month. In preparation for the investigative committee, the members are responsible for reading and reviewing case materials. The preparation for the investigative and full Board meetings usually takes approximately 8 hours per month. In the event of a case with charges that are contested, Board members may be asked to serve on a hearing panel (requires at least three Board members). Some Board members also serve on the licensing committee, which entails an additional monthly meeting that occurs in conjunction with the full Board meeting and additional reading preparation. All Board members attend an initial orientation program and participate in ongoing education concerning Board and regulatory rules and issues.

Members are paid $50 per diem for each day they attend a meeting or sit on a panel. Typical Board meetings last three to four hours; contested hearings vary widely, from as short as a few hours to days long. Members also receive mileage reimbursement and are provided meals at meetings. The time devoted to preparation for meetings (e.g., reading of materials outside of the meeting time) is not compensated.

While much is asked of Board members, the state has been fortunate to have many people dedicated to the work and charge of the Board over the years. We've asked two members, one a physician and one a public member, to share some thoughts about their service.

Much is asked of Board members, but they all seem to enjoy serving. We've asked two members, one a physician and one a public member, to share some thoughts about their service. *Read More*

Member Profiles: Their Stories

Public Member Profile: Sarah McClain

"Serving on the Board has been a truly rewarding experience. Although it was an effort to meet the steep learning curve I faced when I started, it has been rewarding to gain an insider's view of what goes on behind the scenes to protect both the public and our licensees. I've benefitted from this unique and valuable education and gained confidence speaking among a room full of highly educated and committed physicians, lawyers, staff and fellow public members.

The process begins in our monthly investigative committee meetings where a small gathering of physician and public members discuss the facts of each case, intent upon approaching the information without bias. These meetings are an opportunity to dig deeper, ask questions, and voice concerns until we are ready to present a recommended path to closure. We then present these cases in front of the full Board for discussion. I look forward to those round table deliberations where the investigative committees present their cases. It's always interesting to receive the fresh perspective of the other Board members, who are learning about the case for the first time and who must vote to approve, modify, or reject the committee's recommended resolution. These discussions are thoughtful, at times lively and very focused. I am honored to be a part of the vigorous discussion among this group of experienced medical professionals and talented and dedicated Vermonters who serve as public members. "

Sarah was appointed as a public member of the Board in August 2011, and serves on the South Committee and the Licensing Committee. Sarah and her husband Owen Ready-McClain live in Lincoln, Vermont with their two daughters. After graduating from Skidmore College in 2004, Sarah worked in a number of print, web, and film editorial and production positions in Vermont and Washington, D.C. Sarah has been active on a number of community boards and became interested in serving on the Board of Medical Practice when she learned about it through Susan Spaulding, a former public member of the Vermont Board of Medical Practice and President of the Federation of State Medical Boards.

Physician Member Profile: Robert Hayward, MD

"Although I mostly grew up in Virginia and attended medical school there, I am a third generation Vermont physician. My grandfather came here in 1900 and practiced for over 50 years. Two of his sons (my uncles) were also physicians. I returned to Vermont in 1977 to enter residency and have been here ever since. When I was asked to join the Board a few years ago I was happy to have an opportunity to contribute. As an Ob/Gyn I felt it was important that the Board include a member from my specialty. One of the major strengths of the Board is the fact that there is broad physician representation.

As a Board member I feel that I have two important jobs. Number 1 is making sure that the public is protected by ensuring that we hold physicians to standards. Number 2 is ensuring that physicians are not punished unfairly for doing their jobs, while at the same time giving full consideration to each patient's complaint.

There is one observation that I would like to share after having served on the Board for a few years. It seems that many of the complaints that we spend time assessing might never have been brought if the physicians had just done a better job of communicating with their patients. The ultimate goal is not to discipline physicians, but to improve practice, so we are spending more and more time discussing how we can educate physicians about the issues we are seeing in complaints. The rest of the Board and I hope that efforts such as the forums on opioid treatment presented last year were helpful. On the horizon, in addition to the challenges of chronic pain treatment, I anticipate that the Board will be involved in discussions surrounding end-of-life care."

Dr. Hayward has served on the Board since 2010. He completed his residency in Obstetrics and Gynecology in 1981 at FAHC (then known as Medical Center Hospital of Vermont). He was in private practice for over twenty years before joining the staff of FAHC. He has also been an Associate Professor at the UVM College of Medicine. His numerous professional and teaching honors include being Board Certified in Ob/Gyn since 1983 and recognition for excellence in teaching Ob/Gyn.

The Mission, Organization and Processes of the Board of Medical Practice

For over 100 years the Board of Medical Practice has been tasked with licensing and overseeing the practice of medicine in Vermont. On the licensing side, it is the Board's responsibility to ensure that applicants satisfy all statutory criteria, including those for education, competence, and character. Once a license is granted, the Board has an ongoing obligation to investigate possible unprofessional conduct by its licensees. The Board's powers and duties, and the definition of unprofessional conduct, are all found in Chapter 23 of Title 26 of the Vermont Statutes Annotated (V.S.A.) (accessible online at: **http://www.leg.state.vt.us/statutes/sections.cfm?Title=26&Chapter=023).**

It is universally accepted that the primary reason for having a system to license and oversee physicians is public protection. However, protecting the public is not the only benefit of having a Board to oversee the practice of medicine. Public confidence in the profession is also served by having a neutral and independent body to receive, investigate, and, if appropriate, act on complaints and reports of possible unprofessional conduct. It is inevitable that some patients will have misgivings about the quality of the care received. Absent a Board process to handle complaints from the public, there would be no alternative to the courts. It's unlikely anyone would find that desirable. Patients without access to legal representation would lack a way to address concerns. And, in the end, there might be more civil litigation over healthcare.

The Board understands that for many Respondents (the term used for licensees being investigated), the process itself may be a thoroughly unnerving experience. That is not the Board's intent. The goal is no more and no less than to engage in an objective process to collect the evidence necessary and appropriate for the responsible Board members to arrive at informed conclusions in order to dispose of the matter, whatever the outcome. From time to time, the Board hears from Respondents that they feel disrespected in the process. On the other hand, we sometimes hear from Complainants that they believe the Board is an organization dominated by physicians and overly protective of physicians. The reality is that the Board strives to operate within the "just right" zone – respectful of all parties and committed to making fair decisions based on facts.

It is our hope that by sharing information about the Board and our process, we will be able to improve public understanding of the Board's role and the lengths to which the Board goes to fairly and appropriately resolve the matters that come before it.

The Board Members and Staff

The Board of Medical Practice is created by Vermont statute, **26 V.S.A. § 1351**. The Board consists of 17 part-time members, of whom nine must be Vermont-licensed physicians, one must be a Vermont physician assistant, one a Vermont-licensed podiatrist, and six public members not associated with the medical field. All members are appointed by the Governor.

The Board has an Executive Director who is appointed by the Commissioner of Health. There are two full-time investigators and three other administrative staff members who work for the Board in its main office. Two Assistant Attorneys General (AAG) prosecute matters before the Board. Another AAG, assigned to the Department of Health, serves as counsel to the Board. The Board is governed by Vermont law and the Board of Medical Practice Rules. The Board licenses and disciplines physicians, physician assistants, podiatrists, radiologist assistants, and anesthesiologist assistants.

Why Are Investigations Opened?

Cases come to be opened via a number of paths. Most cases begin with a complaint. Complaints may be filed by patient family members, other physicians, other healthcare providers, friends, pharmacists, and others, as well as by patients themselves. The Board receives notice of disciplinary actions by other states' licensing boards, actions on privileges by Vermont hospitals and healthcare institutions, and reports of all malpractice settlements for Vermont-licensed providers. Additionally, some licensees self-disclose incidents. Sometimes there are referrals from other Vermont professional licensing boards, or from the entities that oversee hospitals and other healthcare institutions. There are also times when the Board opens a case on its own initiative, such as when it discovers information relevant to a licensee's actions in the course of investigating another licensee. By law, the Board must investigate all complaints filed against any license holder. **26 V.S.A. § 1353(2).**

How Are Complaints Processed?

The Board is divided into three investigative committees: one that meets in the North, one in the South, and one Central Vermont. These committees meet once a month to review the cases open for investigation. Each committee has a mix of professionals and public members.

When the Board receives a complaint, it is assigned to one of the three committees. Complaints are assigned in a manner to

minimize the potential for conflicts (e.g., a complaint against a northern licensee might be assigned to the south investigative committee). Each case is controlled by the assigned investigative committee. The Board's full-time Executive Director supervises the investigators, but the committees direct the investigators with regard to the gathering of evidence and any focus of concern the committee may have, as the matter proceeds through the investigation.

While every case is unique, some events can be expected. The committee may obtain patient records via a signed release or through a subpoena issued by an AAG. The licensee who is being investigated may be interviewed by an investigator and/or may be asked to appear before the investigative committee to discuss the case. Additionally, the licensee will generally receive an "opening letter" and a copy of the complaint (if there is a written complaint) along with a request that the licensee respond in writing to the allegations.

Given the different circumstances presented by each case, there is no uniform sequence of events to the investigation. In some cases, the investigating committee may gather information first before issuing an opening letter. In other cases, the first step may be the issuance of an opening letter. Tailoring the sequence of events to the particular facts of a case helps ensure that the best possible evidence is presented to the Board, and can also help to assure Complainants of the legitimacy of the investigation process.

Once the appropriate records and other evidence, including interviews and response, have been gathered, the investigating committee reviews the matter to determine whether unprofessional conduct has occurred, as defined in **26 V.S.A. § 1354**. In some cases, the Board may consult with an expert.

The Investigative Committee Reaches a Decision – Then What Happens?

Once the investigative committee reaches a decision, the case is not complete. An investigative committee cannot act on its own. The two basic alternatives are for the case to be closed without action, or for the Board to seek an Order. If the investigating committee determines the case should be closed with no action, then one of a series of closing letters is recommended to the Board. The closing letters vary from a simple notice that the Board has completed its investigation and it is closed, to more detailed letters. The detailed letters may reflect topics discussed in a committee interview or other practice issues that the committee has determined should be addressed. These closing letters remain in a licensee's file and may be reviewed during future investigations, but are otherwise confidential. The Board must approve the resolution of an investigation by closing letter, and hears about each case in executive session.

If the investigating committee determines that a case should not be closed and that findings of unprofessional conduct should be pursued, then by Board rule, the first step is an offer to settle the case. Typically, the AAG will draft a stipulation and consent order that reflects the facts determined by the committee and proposed sanctions. Sanctions vary by case, but might include a reprimand, payment of an administrative penalty, a requirement that a licensee take a continuing medical education ("CME") course, the use of a practice monitor, suspension of a license, or combinations thereof. In some cases, the committee will request that a licensee enter into a Cessation of Practice Agreement.

The AAG will propose the stipulation to the licensee and attempt to negotiate an agreement to be presented to the Board. If the licensee and the AAG (on behalf of the committee) come to terms, the stipulation is signed and submitted to the Board. A hearing officer presents the stipulation to the Board for approval in a public session during a meeting of the full Board. The licensee and AAG may both be present to discuss the stipulation. If the Board members approve the stipulation, it is issued as an Order of the Board, which is posted on the Board's website and is considered a public record. If the Board rejects a stipulation, it goes back to the investigative committee for further discussion of resolution, typically with some suggestions from the Board.

If further negotiations fail to lead to a new agreement on a stipulation, then the investigating committee will ask the AAG to file charges of unprofessional conduct. The AAG is subject to an ethical obligation that prohibits bringing a case that lacks a basis in law or fact. A hearing panel made up of at least three Board members (who are not members of the investigating committee) is appointed. A hearing officer is used to assist with the hearing process. An administrative hearing is held where witnesses and evidence may be presented by both sides. The hearing panel will issue a recommendation with its findings of fact and proposed sanctions, if any. The full Board then takes up the recommendation of the hearing panel and determines whether to adopt the hearing panel's recommendation. The Board makes a final ruling, which becomes an Order of the Board, is posted on the Board's website and becomes a public record. Appeals from the Board's ruling go directly to the Vermont Supreme Court and follow the regular appellate process. **23 V.S.A. §1367**

How Long Does The Process Take?

The investigative process usually ranges from two to twelve months. However, if a case progresses to a contested hearing with multiple witnesses, the process will often take much longer.

The minimum of two months reflects time needed for the licensee to receive and respond to the complaint, the committee to review material, and closure at the following full Board meeting. This all takes time, especially in light of the fact that the committees and the Board meet only once each month.

What About the Numbers?

The number of cases varies from year to year, but at present the number expected number for calendar year 2013 is about 350. In recent years, the number of cases that resulted in actions against a licensee has been about ten to fifteen (there are many more actions, but many of them concern cases that have already been the subject of a disciplinary order). On the whole, the rate of cases in which there is a finding against the licensee is roughly five percent. Also, invariably, in a majority of cases in which there is a finding against the licensee, there is a stipulated agreement.

What Protections Are Afforded to Licensees?

Given the fact that many cases do not result in action against the licensee, one of the most important protections for the Respondent is statutory confidentiality of Board investigations, which protects the licensee's reputation from any damage that might otherwise result from a case that is not substantiated. Pursuant to **26 V.S.A. § 1318**, each case remains confidential, unless and until there are charges or a stipulation to discipline. In the event there are charges, it becomes a public process, but the express purpose of the statute, stated in the law itself, is "to protect the reputation of licensees from public disclosure of unwarranted complaints." However, confidentiality has its limits. For instance, a Complainant can tell others that he or she has complained, but the Board will not publicly disclose the investigation absent charges or a stipulated order.

Another important protection is that the licensee is entitled to due process. The Respondent has rights, and the case cannot proceed in a manner that violates either the generally applicable principles of due process that apply to administrative hearings in Vermont, or the rights specified in the Board statute. The Respondent is guaranteed at least 30 days to prepare from the date of service of charges (but typically more time is allowed under an agreed schedule). Respondents also have the right to be notified of the charges, the right to appear, the right to have counsel appear, the right to produce witnesses and evidence in their own behalf, the right to cross-examine witnesses, and the right to examine all documentary evidence. In sum, it is a fair contest, the focus of which is to generate an examination of the evidence in order to allow for a decision based upon the facts as may best be established.

Finally, licensees should remain aware that a *majority* of Board members are peers – M.D.s who well understand the realities of practice, and who will be subject themselves to the rules and precedents that they establish. Furthermore, while the Board's mission is to protect the public, every member understands that protection of the public is not achieved simply by taking actions against licensees. They understand that *warranted* actions to address and deter unprofessional conduct are necessary, but so is it necessary for fit and qualified licensees to be able to practice and to be able to do so without fear of unwarranted actions.

In Closing

The Board does its best to make the investigation process as smooth as possible for all involved while at the same time being faithful to its duty to protect the public. Anyone with questions or concerns about the Board's investigation process should call or write the Board's Executive Director.

Vermont M.D. License Renewal Now Requires CME

Beginning at the start of the current licensing cycle (December 1, 2012 – November 30, 2014), physicians licensed by the Vermont Board of Medical Practice must complete 30 hours of continuing medical education in each two-year license period in order to be eligible to renew for the succeeding license period. The new requirement is based upon a change to Vermont law, which required the Board to adopt rules mandating CME. The Board has communicated this new requirement through a number of emails, announcements on our web page, and via organizations such as the Vermont Medical Society. The Board's staff continues to hear questions from physicians about the new requirement, so we have collected questions and answers to share here.

1. Where do I find the official rules?

The rules are available on the Board's website, which you can reach by clicking **here**.

2. To whom does the new requirement apply?

These requirements apply to physician licensees of the Vermont Board of Medical Practice. They do not apply to other professions licensed by the Board.

3. What is the overall requirement?

Thirty hours of AMA Physician's Recognition Award Category 1 Credit ™ (AMA PRA Category 1 Credit™).

4. What are the subject requirements?

The basic requirement is that the CME be designed to update knowledge and skills in the physician's own specialties and fields for which patient referrals may be appropriate. The requirement is not to be read narrowly; it is acknowledged that training in many fields may be reasonably related to one's own area of practice.

In addition, there are two subject-specific requirements, one that applies to every licensee and one that applies only to those licensees who hold or who have applied for a DEA number. The requirement for each topic is at least one hour on the specific subject, and in each instance it's not an additional hour. Subject-specific activities count toward the 30-hour requirement.

The first required subject is hospice, palliative care, and pain management services. This requirement comes directly from the statute. There is no specific course that must be taken; the requirement is simply that at least one hour of the 30 must be on one of those topics, or a combination thereof. The other requirement, which is triggered by having a DEA number to prescribe controlled substances, is for at least one hour on safe and effective prescribing of controlled substances. You may devote more than one hour to either of the special subjects; the requirement for one hour is a minimum amount of training on those subjects.

5. What is the period during which I must complete CME?

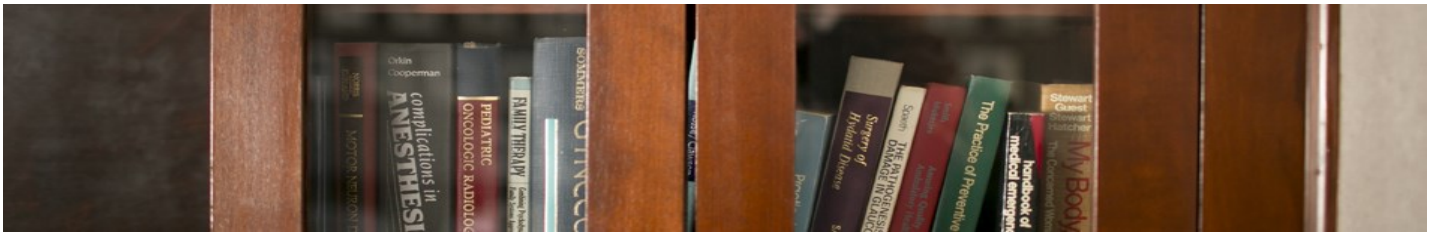
The period is the licensing cycle, which is always a two-year period beginning on December 1 of an even year and ending on November 30 two years later. The initial period to complete the required CME is December 1, 2012 to November 30, 2014, with participation in qualifying activity being a prerequisite for renew of a license for the period December 1, 2014 to November 30, 2016. For this initial cycle only, CME completed during the six-month period preceding December 1, 2012 will be allowed to count toward the 30-hour requirement.

6. How are hours reported?

The requirement will be for the licensee to certify that he or she has satisfied the CME requirements at the time when the renewal application is submitted. It will not be necessary to submit certificates of completion at that time. However, the rules provide that licensees are subject to being audited and, if selected for audit, can be required to submit documentation for up to four years. At present (July 2013), the Board does not offer licensees the means to track and store documentation, but we are working with our software consultant and expect to offer that capability by late 2013 or early 2014. Licensees will be able to record information about their CME activities and upload documentation. We will notify everyone when that is available.

7. What if I am not licensed for the entire two-year period?

If you were newly licensed in Vermont for the first time as an M.D. during the 2012 to 2014 licensing period, your requirement will depend on when your license was issued.



If your first license was issued after December 1, 2013, CME will not be a requirement for your first renewal. If licensed for the first time before December 1, 2013, your requirement will be 15 hours of qualifying CME. Those with a requirement for 15 hours must satisfy the requirement for at least one hour of training on hospice, palliative care, and pain management services. In addition, those with a DEA number must satisfy the requirement for at least one hour of training on safe and effective prescribing of controlled substances.

8. What if a physician has not completed CME in time to renew?

A physician who has not completed required CME in time to renew his or her license will be able to renew so long as an acceptable make-up plan is filed along with the renewal application. A make-up plan must include a list of the activities that the physician plans to complete in order to meet requirements in the first 120 days of the license period. The rules include additional procedures for licensees who fail to complete a make-up plan.

9. What if I'm in the military and unable to complete CME because of a deployment?

There is a special rule for licensees who are subject to a military deployment. If the deployment lasts for more than a full year during a licensing cycle, the licensee is not required to complete CME during that cycle. If the mobilization is for less than a year during the license period, then the physician is subject to the 15-hour requirement (see #7).

10. Do physicians earn credit by being faculty for CME training?

Yes. The AMA PRA program allows two credits for each hour presenting courses that qualify for AMA PRA Category 1 Credit™. The Board follows the same standard.

11. I'm not sure if a course meets the requirements for subject-specific training. Will the Board approve courses in advance?

Yes, the Board will advise physicians if particular courses meet the subject-specific requirements. Contact by email is recommended.