BOARD OF MEDICAL EXAMINERS
FULL BOARD MEETING
Homewood Suites by Hilton
1023 Baxter Lane
Bozeman, MT 59715
DATE: May 19 - 20, 2011

MINUTES

AMERICANS WITH DISABILITIES ACT:
The Department of Labor and Industry is committed to providing meeting access through reasonable accommodation under the Americans with Disabilities Act. Please contact the Board office prior to the proposed meeting date for further information.

ITEM # 1: Call to Order

Dr. Anna Earl called the meeting to order at 8:05 AM. Roll call was taken and a quorum was present.

Members Present: Dr. Dean Center, Dr. Mary Anne Guggenheim, Ms. Pat Bollinger, Dr. James Upchurch, Dr. Nathan Thomas, Dr. Bruce Hayward, Mr. Ryan Burke, Dr. Kristin Spanjian, Dr. Anna Earl, Ms. Carole Erickson

Members Absent: Ms. Eileen Sheehy, Ms. Kay Bills-Kazimi, Mr. Dwight Thompson

Staff Present: Ms. Jean Branscum, Ms. Anne O'Leary, Ms. Linda Ashworth, Mr. Ken Threet

Guests Present: Dr. Harry Sibold, Mr. Mike Ramirez, MPAP; Mr. Jim DeTienne, DPHHS; Dr. Don Helland; Erin MacLean, Montana Medical Association; Mr. Ron Klein, Executive Director, Montana Board of Pharmacy; Dr. Gary Mundy; Dr. James Armstrong; Dr. Donna Alderson; Ms. Tanya Brekke, Montana Association of Acupuncture and Oriental Medicine; Ms. Pat Wilson, Kalispell Regional Hospital; Dr. Esther Barnes, Kalispell Regional Hospital; Dr. Brent Duchele, Kalispell Regional Hospital; Dr. A. Craig Eddy, Kalispell Regional Hospital; Dr. Jon Thomas, Federation of State Medical Boards; Dr. Francis Cain, Federation of State Medical Boards

ITEM #2: Approval of Agenda:

The May 19-20, 2011 agenda was submitted for approval. Dr. Anna Earl requested that agenda item #6 be switched with agenda item #7.

MOTION: Ms. Pat Bollinger made a motion to approve the change and to accept the May 19 -20, 2011 agenda. Dr. Kristin Spanjian seconded the motion. The motion passed unanimously.

ITEM #3: Approval of Minutes

The Board reviewed the March 18, 2011 minutes. On page 7, under item (B – Kristine Johnson), first paragraph, the word "pulled" was amended to read "tolled".

MOTION: Dr. Mary Ann Guggenheim made a motion to approve the March 18, 2011 minutes as amended. Dr. Bruce Hayward seconded the motion. The motion passed unanimously.

The Board reviewed the March 18, 2011 Executive Session minutes.

MOTION: Dr. Bruce Hayward made a motion to approve the March 18, 2011 Executive Session minutes. Dr. Kristin Spanjian seconded the motion. The motion passed unanimously.

ITEM #4: Open Forum for Public Comments

PUBLIC COMMENT STATEMENT:

In accordance with 2-3-103(1), MCA, the Board will hold a public comment period. Please note that Open Forum is the public's opportunity to address the Board on any topic that is not on the agenda for this meeting. While the board cannot take action on the issues presented, the Board will listen to comments and may ask the issue be placed on a subsequent agenda for possible action by the Board. The Chairperson of the board will determine the amount of time allotted for public comment.

Dr. Anna Earl opened the meeting for public comment. There was no public comment.

ITEM #5: Licensee Administrative Action

A. Dr. James Armstrong

Dr. Armstrong requested that the discussion be moved to executive session. Dr. Anna Earl called the meeting into executive session to discuss Dr. James Armstrong's petition to lift the five-year restriction on his license.

Dr. Earl called the board meeting back into open session.

MOTION: Dr. Mary Anne Guggenheim made the motion. Dr. James Upchurch seconded the motion. The motion passed unanimously.

B. Dr. Julie Swanson

Dr. Swanson did not attend the meeting. Dr. Swanson was before the Board at the March 18, 2011 meeting because a gap in time, when she ceased to practice, was missed during the application review and she was granted a full unrestricted license on September 13, 2010. The Board passed a motion to allow Dr. Swanson to take the SPEX. If she were to not pass the exam the Board would take further action. Dr. Swanson has passed the SPEX and presented the scores to the Board. No further action was needed regarding her licensure.

ITEM # 6: Unlicensed Practice

Ms. Anne O'Leary referenced a memo from the Legal Unit that stated that any complaint against a licensee or an unlicensed person should be held in executive session until such time, if any, that the complaint is corroborated via finding of reasonable cause.

A. Complaint Number: 2011-111-MED

Dr. Anna Earl called the meeting into executive session to discuss an unlicensed practice complaint.

Dr. Earl called the board meeting back into open session.

MOTION: Dr. Dean Center moved to dismiss the complaint against without prejudice pending confirmation of staff that the named Montana-licensed physician would be supervising the reading and interpreting of the studies. Dr Kristin Spanjian seconded the motion. The motion passed unanimously.

ITEM # 7: Non-Routine Licensure Applications

A. Dr. Donna Alderman

Dr. Alderman attended the meeting via telephone. The board discussed Dr. Alderman's application. Dr. Alderman's application was before the Board because she had only completed one year of residency prior to licensure in California. Dr. Alderman graduated from medical school in 1995.

Montana Administrative Rule 37-3-3-5 (c) states:
Qualifications for licensure. (1) Except as provided in subsection (4) and (5) a person may not be granted a physician's license to practice medicine in this state unless the person:(c) has successfully completed an approved residency program of at least 2 years or, for an applicant who graduated from medical school prior to 2000, has had experience or training that in the opinion of the board is at least the equivalent of a 2-year approved residency program.

MOTION: Dr. James Upchurch moved to award full and unrestricted licensure to Dr. Donna Alderman. Dr. Kristin Spanjian seconded the motion. The motion passed 9-1 with Dr. Dean Center voting no.

B. Dr. Christopher Peters

Dr. Peters did not attend. Numerous attempts to notice Dr. Peters that his application would be discussed before the full board were unsuccessful. Dr. Peters' application was before the Board because of a pending malpractice issue and a case that was settled in 2002 for

$17,000. At the time a letter of warning was issued by the Iowa Medical Board. Dr. Peters sent a letter expressing his displeasure for the warning and the Iowa Medical Board upheld its decision on 4/21/2005.

Dr. Peters answered "no" on question #10 of the addendum of his application regarding disciplinary action from a licensing. When given the chance to change his answer to "yes" he stated that he would not change his answer.

Another case was filed by the Iowa Board of Medicine in 2009 concerning a handgun being found in his bag during a surgical procedure. The Iowa board did not pursue formal disciplinary action because this did not impact patient care. Dr. Peters had originally answered "no" to question #12 on the addendum to his application regarding a complaint being filed against him with a professional or occupational licensing agency. He was given the choice to change his answer to "yes" and he did amend the answer.

MOTION: Ms. Carole Erickson made a motion to table the review of Dr. Peters' application until the July meeting when Dr. Peters could be present. Dr. Nathan Thomas seconded the motion. The motion passed unanimously.

C. Rachel Moore, EMT

Ms. Moore did not attend the meeting. Her application for EMT Basic was before the Board because of numerous driving infractions, several of which included the use of alcohol. The Board discussed her application and because of the seriousness of the driving infractions, deemed it necessary that Ms. Moore appear before the Board in person.

MOTION: Ms. Carole Erickson made a motion to table the review of the application until the July meeting, at which time Ms. Moore would be requested to appear before the Board in person. Dr. Dean Center seconded the motion. The motion passed unanimously.

Mr. Jim DeTienne, DPHHS, thanked the Board for taking the issue of impaired driving records of applicants for EMT licensure, seriously.

D. Dr. Gary Mundy

Dr. Mundy attended the January 21, 2011 full board meeting. He had not worked since 2007 and had requested that the Board sponsor him for the SPEX. At that time the Board had discussed his application. The Board passed a motion to sponsor Dr. Mundy for the SPEX and if he passed his application would then be considered for licensure.

Dr. Mundy attended the meeting by phone. His successful completion of the SPEX was provided to the Board.

MOTION: Dr. James Upchurch made a motion to grant a full unrestricted license for physician licensure to Dr. Gary Mundy. Dr. Kristin Spanjian seconded the motion. The motion passed unanimously.

E. Dr. Don Helland

Dr. Helland attended the board meeting in person. His application was before the Board because his California license was suspended in January 2003, because of methamphetamine and alcohol abuse. He entered the California Diversion Program for a period of 5 years. Suspension of his license was lifted in April of 2004 and he successfully completed the program in December 2007. Mr. Mike Ramirez met with Dr. Helland on November 10, 2010 and on the basis of the interview he recommended full and unrestricted licensure.

The Board questioned the reason Dr. Helland was making a career change from radiology to primary care and also expressed concern that moving to a small community in Montana would not offer the support needed to maintain his continuing rehabilitation.

In order to buffer the stresses of working in a small Montana community the Board recommended Dr. Helland agree to be monitored by MPAP for one year and establish a relationship with one or more of the regional physicians.

MOTION: Dr. Mary Anne Guggenheim made a motion to grant Dr. Helland a full unrestricted license with the caveat that Dr. Helland voluntarily enter into a MPAP agreement, relevant to his rehabilitation, to be monitored for one year. Dr. Upchurch seconded the motion. The motion passed 8-1 with Mr. Ryan Burke voting no and Ms. Carole Erickson abstaining from the vote.

Mr. Mike Ramirez agreed to introduce Dr. Helland to physicians in the area.

ITEM # 8: Administrative Rules

A. MAR 24-156-75 – Acupuncture and PA Rules

Ms. Jean Branscum reported that the Acupuncture and PA Rules were in the process of moving forward toward adoption.

B. Temporary Resident and Physician Licensure Rules

Ms. Anne O'Leary reported on the changes to the temporary resident and physician, and inactive retired physician rules. The Board discussed the changes. The final document is attached to the minutes.

MOTION: Dr. James Upchurch made a motion to notice the rules with the changes to the temporary resident, physician and inactive retired physician rules. Dr. Mary Anne Guggenheim seconded the motion. The motion passed unanimously.

C. Inactive Retired Physician Rules

The dialogue and motion for the inactive retired physician rules was discussed in conjunction with the temporary resident and physician licensure rules in part B of this agenda item.

D. EMT Rule Update

Ms. Jean Branscum provided the background to the proposed changes to the EMT rules. Ms. Anne O'Leary presented the changes to the board members.
The final proposed rule changes are attached to the minutes.

MOTION: Dr. Dean Center made a motion to accept the EMT rule changes as discussed and to file the rule change packet. Dr. James Upchurch seconded the motion. The motion passed unanimously.

E. Reporting Obligation rules for PAs, Podiatrist, and Telemedicine

Ms. Jean Branscum noted that the rule would also state that PAs and physicians are now obligated to inform the board of termination of supervision agreements within thirty days. Ms. Branscum noted that it was a future goal to list the supervision agreements attached to each physician on the website. The final proposed rule changes are attached to the minutes.

MOTION: Dr. Center made a motion to accept the reporting obligation rules for PAs, podiatrists and telemedicine changes and to notice the rules change package. Dr. Kristin Spanjian seconded the motion. The motion passed unanimously.

ITEM # 9: WORKING LUNCH AND MPAP REPORT

Dr. Anna Earl called the meeting into executive session to discuss the MPAP Report.

Dr. Earl called the board meeting back into open session.

Mr. Mike Ramirez presented a brief CD introduction to the Montana Professional Assistance Program.

Dr. Anna Earl thanked Mr. Ramirez for his work with MPAP and his assistance to the Board of Medical Examiners.

ITEM #10: Position Papers

A. Statement of physician prescribing for self or members of the physician's immediate family.

Ms. Jean Branscum presented the revised position paper entitled, "*Statement of Physician Prescribing for Self or Members of the Physician's Immediate Family".* The last paragraph was amended to read, "In conclusion, the Board of Medical Examiners would encourage Montana-licensed physicians to consider carefully the legal and medical disadvantages of prescribing for self or immediate family members. If after due consideration, the physician elects to issue such prescription, the Board would urge the physician to protect both himself or herself, and the family member, with appropriate medical records supporting the prescriptions."

The board members discussed the position paper and suggested several changes. The final proposal is attached to the minutes.

MOTION: Dr. James Upchurch made a motion to accept the position paper with the additional changes as discussed. Dr. Kristin Spanjian seconded the motion. The motion passed unanimously.

B. Medical Ethics

Ms. Jean Branscum presented the draft position paper entitled, *"Ethics for Medical Professionals"* which was originally passed by the Board in 2009*.* Ms. Branscum noted that it had never been posted and asked that it be reviewed again for accuracy. The last sentence of the first paragraph was deleted. The final proposal is attached to the minutes.

MOTION: Dr. Kristin Spanjian moved to accept the Medical Ethics document with the edited changes. Dr. Mary Anne Guggenheim seconded the motion. The motion passed unanimously.

ITEM #11: Legislative Report

A. SB 423 – Revise Laws Relating to Use of Medical Marijuana

Ms. Branscum noted that SB 423 would go into effect without the Governor's signature. A petition is currently circulating to put the law on the ballot in 2012. More signatures would assure that the law would not go into effect until after the 2012 vote, leaving the current statute in place. The proposed rule package would address the issues that will go into law on July 1, 2011. Ms. Branscum and Ms. O'Leary met with DPHHS to offer suggestions for rules for an emergency rules package that would clarify the Board's role in peer review that would relate to the review process for physicians providing written certifications for 25 or more patients and the fee to be charged for the cost incurred for the Board's review of a physician's practice in providing written certification.

The Board will continue to monitor the emergency rules from DPHHS regarding the reporting of names to the Board of Medical Examiners. The final rule package proposal is attached to the minutes.

MOTION: Dr. Mary Anne Guggenheim made a motion to send the rule draft for SB 423 to DPHHS. Dr. Kristin Spanjian seconded the motion. The motion passed unanimously.

B. HB 25 – Revise Law Related to Medical Assistance Programs

Ms. Jean Branscum reported that the passage of HB 25 made consistency across the board in all the medical assistance programs. The current rule related to the medical assistance programs was provided along with the proposed amendment to relapse reporting. The board members reviewed the proposed amendment.

Ms. Branscum noted that with the passage of HB 25 all the rules would relate to every occupation. All the rules need to be in each occupational area.

MOTION: Dr. Kristin Spanjian made a motion to file the rule notice amending the physician rules related to relapse reporting, and amending the rules for all other occupations licensed by the board to include language regarding medical assistance programs. Ms. Pat Bollinger seconded the motion. The motion passed unanimously.

The final rule notice is attached to the minutes.

C. SB 27 – Provide Acupuncturist on Board of Medical Examiners

Ms. Jean Branscum noted that the passage of SB 27 added an acupuncturist to the Board of Medical Examiners. She provided the fiscal note placing the cost at $3835 per year for the new board member. During the legislative session the acupuncturists had agreed to an increase of their licensing fees to cover the costs that would result in an increase in fees of 50%, increasing the cost to licensees by $26.60 per year. Ms. Branscum provided a survey comparing the costs of acupuncture licensure from surrounding states.

Ms. Branscum reported that with the new database, the board would absorb a one-time cost of $200,000 for the new database. Additional ongoing costs have been projected at $44,513 maintenance per year for the system. In order to spread the cost equally to licensees by 10% the increase would be $4.23. She also noted that the Board would likely see an increase in fixed costs, contract costs and personnel cost.

The Board discussed the following options:

1. Increase renewal fees to $53.20 to cover the board member cost.

2. Increase renewal fees to cover board member and database maintenance costs from $100 to $160 and raise the applicant fee to $100.
3. Hold off increasing fees until FY 2112 budget is set.

MOTION: Dr. Kristin Spanjian made a motion to approve increasing the acupuncture renewal fees, to cover the board member and database maintenance costs, from $100 to $160 and raise the applicant fee to $100. Ms. Carol Erickson seconded the motion. The motion passed unanimously.

The final rule notice is attached to the minutes.

D. HB 83 – Prescription Drug Registry

Mr. Ron Klein, Executive Director of the Board of Pharmacy provided information on HB 83, which establishes a prescription drug registry that will be housed with the Board of Pharmacy. The Board of Pharmacy is in the process of writing administrative rules. The rules will be provided to the Board of Medical Examiners for comment.

Mr. Klein noted that all physicians that prescribe medication will have access to the register. The goal is to have the system up and running by January 1, 2012. To support the system, the 2011 Legislature authorized the assessment of a $15 fee per year, to be paid directly to the Board of Pharmacy, by any practitioners that prescribe controlled substances.

Ms. Jean Branscum noted that the MMA lobbied for establishing a sunset on the law and also for the $15 fee. She also mentioned that the Board of Medical Examiners was a strong advocate for the registry program.

E. Legislative Tracking

Ms. Jean Branscum provided the legislative tracking report from the 2011 Legislative Session.

F. Other

a. HB 94 – Revise Professional and Occupational Licensing Laws

Dr. Kristin Spanjian reported that she had been in contact with the Board of Dentistry regarding rules related to physician anesthesia. Ms. Branscum thanked Dr. Spanjian for her work with the Board of Dentistry as the bill moved through the legislative process. Once the rules are developed the board will have a chance to comment.

b. HB 642 – Committee on Efficiency in Government

Ms. Branscum reported that HB 642 forms a committee to look at efficiency of government. The committee will review statutes that address the licensing of healthcare professionals to insure that the licensing requirements are appropriate for current and future healthcare practices. She noted that the board would want to be actively involved in this committee.

c. SB 120 – Publishing of Contact Information for Board Members

Ms. Jean Branscum reported that SB 120 requires contact information about members of state agency boards, committees, commissions and advisory councils to be provided for publication. This information is to be either the address, telephone number or e-mail address for each member.

The board contact information was dispersed to each member. Members were asked to circle information on the document that they would like to have published as contact information on the website.

d. SJ 18 - Interim Study on Health Care workforce Development Initiatives

Erin MacLean, Montana Medical Association, queried the Board's following of SJ18. Ms. Branscum reported that the Board had supported the resolution. She noted that the department has expressed interest in having the board be part of the committee. The Board will continue to monitor the progress.

ITEM #12: Committee Reports

A. Laws and Rules Committee

Dr. Mary Anne Guggenheim reported that the Laws and Rules Committee had met May 10, 2011 to review the proposed rule changes and position papers discussed and voted on earlier in the day.

Ms. Carole Erickson reported that the Disruptive Physician Subcommittee had met on May 18, 201. She stated that the disruptive professional behavior position paper would be developed and brought to the July board meeting. She noted that the term "disruptive physician behavior" would be changed to "disruptive medical professional".

B. Medical Director Committee

Dr. James Upchurch updated the Board on nurses working in pre-hospital settings. The position paper directs that the EMS director will ensure the competency of the nurse before being allowed to work in the pre-hospital setting. The paper will be published on the website. Dr. Upchurch noted that the Board of Nursing was in agreement with the document.

MOTION: Dr. Bruce Hayward made a motion to accept the white paper. Mr. Ryan Burke seconded the motion. The motion passed unanimously.

Dr. James Upchurch introduced a recommendation from the Medical Director Committee entitled, "Independent Learning Components/Distance Learning".

This item had not been posted on the agenda so was moved to the July meeting

Dr. Upchurch reported that the Board had assigned the task of reviewing the national educational model for EMT education and scope of practice to allow licensees portability and consistency in educational and licensure requirements. The committee felt that Montana would benefit and developed an implementation plan to be approved by the Board. Upon approval, rules would be drafted to implement the changes and then presented to the Board for approval. The committee felt the draft rules should also be provided to the EMTs in the field for informal input.

MOTION: Dr. Dean Center made a motion to adopt the implantation plan. Mr. Ryan Burke seconded the motion. The motion passed unanimously.

C. Outreach Committee

Ms. Carole Erickson reported that the Outreach Committee had met on May 13, 2011. She thanked Ms. Jean Branscum, Dr. Mary Anne Guggenheim and Ms. Pat Bollinger for their work during the legislative session. She also thanked Dr. Dean Center and Dr. Kristin Spanjian for their work on the articles submitted by the Board to the Montana Medical Association.

Ms. Erickson reported that the eNewletter had been sent to members via the list serve and the "reply to all" response had not been disabled allowing a large number of responses to be sent to the members on the list. Many members were upset and have asked to be taken off the list serve. Ms. Jean Branscum will draft a personal letter of apology from the Board to be included in upcoming mass mailing to the licensees. A hard copy of the upcoming eNewsletter could also be included in the mailing.

Ms. Erickson reported that Ms. Branscum had provided a PowerPoint presentation that she developed to be presented to the Rocky Mountain College PA Studies Program and the Montana Association of Medical Staff Service Conference. Ms. Erickson suggested that the presentation could be used as part of a new board orientation packet. Board members were asked to submit a list of three things they wish they had known then that they know now.

Work continues on the Montana Board of Medical Examiners website.

ITEM #13: EMT Testing sites and Mobile Testing

Due to lack of time the EMT testing sites and mobile testing report will be moved to the July agenda.

MOTION: Dr. James Upchurch made a motion to move agenda item # 13 to the July agenda. Dr. Dean Center seconded the motion. The motion passed unanimously.

ITEM #14: Board Communications

A. **Request from Dr. A. Craig Eddy regarding podiatrists administering Hyperbaric Oxygen Therapy (HBO)**

Ms. Pat Wilson, Dr. Esther Barnes, DPM; Dr. Brent Duchele, Medical Director of HBO Program; and Dr. A. Craig Eddy, Chief Medical Officer from Kalispell Regional Hospital joined the conversation by phone to discuss allowing Dr. Esther Barnes, DPM to administer Hyperbaric Oxygen Therapy (HBO) for the conditions of the human functional foot and ankle.

Ms. Wilson, Dr. Barnes, Dr. Duchele, and Dr. Eddy agreed to work with the Board on developing rules to allow podiatrists to perform the procedure. Ms. Anne O'Leary noted that there was no statutory limitation on podiatrist administering HBO therapy.

MOTION: Dr. Spanjian made a motion to charge the rule making regarding podiatrists administering Hyperbaric Oxygen Therapy (HBO) for the conditions of the human functional foot and ankle to a subcommittee to include Dr. Harry Sibold, Dr. Esther Barnes, Dr. A. Craig Eddy, Dr. Nathan Thomas and Ms. Anne O'Leary. Dr. James Upchurch seconded the motion. The motion passed unanimously.

Ms. Wilson will contact the board office with email addresses of the participants from Kalispell Regional Medical Center. The goal will be to present a draft at the July meeting.

B. Itinerant Surgery – Montana Medical Association

Ms. Jean Branscum presented a letter from the Montana Medical Association requesting the Board's opinion on physicians performing itinerate surgery. Ms Anne O'Leary noted that these physicians do not have hospital privileges yet have preferred status at Blue Cross/Blue Shield of Montana. No arrangements are made for post operative care either by local ophthalmologists or emergency room coverage.

Erin MacLean noted that MMA feels this is an important issue and is looking for guidance and appropriate protocol, possibly through a position paper on outreach surgical procedures, from the Board of Medical Examiners. The issue was referred to the Physician Provider Committee. MMA will offer input once the committee meets.

MOTION: Ms. Carole Erickson made a motion to refer the issue of itinerate surgery to the Physician Hospital Provider Committee to develop a position paper. Dr. Bruce Hayward seconded the motion. The motion passed unanimously.

C. Correspondence from Dr. David Christianson, Billings, MT re: Medical Marijuana

Correspondence from Dr. David Christianson was provided to the board members. The correspondence was informational only.

ITEM #15: Federation of State Medical Board

A. Annual Meeting Report

Dr. Mary Anne Guggenheim provided a brief report on the recent FSMB national conference in Seattle, Washington April 27-30. Ms. Carole Erickson, Public Member, and Ms. Linda Ashworth, Program Manager, also attended the meeting. Dr. Guggenheim reported that the theme, Workforce in Transition, centered on the topics of re-entry into clinical practice, maintenance of licensure and telemedicine/technology – assisted medicine.

Dr. Guggenheim noted that FSMB has offered a "free" SPEX exam to a board member. She indicated that she would be willing to take the exam.

B. Communications – No action needed

ITEM #16: Community Para-Medicine

Dr. James Upchurch presented the Community Para-Medicine Implementation Plan, stating that community paramedicine would coordinate existing community resources to decrease costs and improve the quality of healthcare within communities. EMTs and paramedics would provide appropriate care by assessing the appropriate level of care and connect the patient with an available healthcare resource. The EMT would be required to have additional 60-80 hours of training to expand their role without expanding their scope. The community would determine the gaps in the community healthcare and the EMT would fill in the scope.

Dr. Upchurch provided a copy of Minnesota law that recognizes the community paramedic and authorizes Medicaid to pay for the services.

Mr. Jim DeTienne reported that on the national level they are looking at identifying community paramedicine and recognizing that it should be reimbursed.

MOTION: Dr. Mary Anne Guggenheim made a motion to recess the meeting until 8:30 AM Friday, May 20, 2011. Ms. Carole Erickson seconded the motion. The motion passed unanimously. The board meeting was recessed at 5:25 PM.

CONTINUED ON FOLLOWING PAGE

BOARD OF MEDICAL EXAMINERS
FULL BOARD MEETING
Homewood Suites by Hilton
1023 Baxter Lane
Bozeman, MT 59715
DATE: May 20, 2011

AMERICANS WITH DISABILITIES ACT:
The Department of Labor and Industry is committed to providing meeting access through reasonable accommodation under the Americans with Disabilities Act. Please contact the Board office prior to the proposed meeting date for further information.

ITEM # 1: Reconvene Meeting

Dr. Anna Earl reconvened the meeting at 9:00 AM.

Members Present: Dr. Dean Center, Dr. Mary Anne Guggenheim, Ms. Pat Bollinger, Dr. James Upchurch, Dr. Nathan Thomas, Dr. Bruce Hayward, Mr. Ryan Burke, Dr. Kristin Spanjian, Dr. Anna Earl, Ms. Carole Erickson

Members Absent: Ms. Eileen Sheehy, Ms. Kay Bills-Kazimi, Mr. Dwight Thompson

Staff Present: Ms. Jean Branscum, Ms. Anne O'Leary, Ms. Linda Ashworth, Mr. Ken Threet

Guests Present: Dr. Jon Thomas, FSMB; Dr. Francis Cain, FSMB

ITEM #17: Office Staff Reports

A. Executive Director Report

a. Budget Report

The Board was provided a copy of the budget report for review. Dr. Dean Center commended the Board, administration and staff for working within the budget.

b. State Medical Director Update

Ms. Jean Branscum introduced Dr. Harry Sibold. Dr. Sibold has been hired as the new State Medical Director. His projected start date will be between September 1 - October 1, 2011. Ms. Branscum asked the Board to consider sending Dr. Sibold to national training for medical directors.

MOTION: Dr. James Upchurch moved to send Dr. Harry Sibold to the national training for medical directors in order to provide training for his new position as State Medical Director. Dr. Bruce Hayward seconded the motion. The motion passed unanimously.

Ms. Branscum requested the Board cover the cost of Montana licensure for Dr. Sibold.

MOTION: Dr. Kristin Spanjian made a motion to cover the cost of Montana licensure for Dr. Harry Sibold. Ms. Carole Erickson seconded the motion. The motion passed unanimously.

c. Professional Assistance Program RFP

Ms. Jean Branscum reported the RFP for the Profession Assistance Program and the Peer Review Program are at the end of the seven-year cycle. Ms. Branscum reported that the VeriDoc agreement had been changed. For every $20 charged by VeriDoc the Board of Medical Examiners will receive $10, adding up to approximately $5000/year.

B. Legal Report

Ms. Anne O'Leary did not have additional information to report at this meeting.

C. EMT Report

The Board was provided a copy of the EMT report for review.

D. Program Manager Report

The Board was provided a copy of the application report for review.

ITEM #18: Compliance Report:

Ms. Jean Branscum presented the compliance report to the Board and updated the members on the earlier screening panel discussions. The panel reviewed 8 cases. 5 cases were tabled, 1 was dismissed with prejudice and 2 cases without prejudice.

ITEM #19: FSMB Presentation

Dr. Anna Earl introduced Dr. Jon Thomas and Dr. Francis Cain, Federation of State Medical Boards. Dr. Thomas and Dr. Cain gave a presentation on Telemedicine and its use in portability of licensure and its use in technology assisted medicine and maintenance of licensure.

The Board discussed the possibility of working with FSMB on a pilot program for maintenance of licensure (MOL). The Board will present the idea of MOL in the MMA newsletter and request feedback. The eNewsletter could also be used to survey licensees. The Board decided to revisit the issue at a later time and possibly join the pilot program at a later date.

Dr. Thomas and Dr. Cain informed the Board that the progress of the pilot program would be available on the FSMB website and if the Board decides at a later date to join the MOL pilot program FSMB will be available to help the Board.

ITEM #20: Adjournment

MOTION: Dr. Kristin Spanjian made a motion to adjourn the meeting. Ms. Carole Erickson seconded the motion. The meeting was adjourned at 2:20 PM.

Additional Documents Attached

5/19/2011 Board Meeting: Agenda Item 8. A. and B.

Administrative rule changes for physicians and residents. Items underlined are amendments to current rule and the text struck out signifies deletion from current rule text. New rule proposals are at the end of this document and are assigned a rule later in the process by board counsel.

24.156.501 DEFINITIONS For the purpose of these rules, the following definitions shall apply:

(1) Words importing the singular number may extend and be applied to several persons or things; words importing the plural number may include the singular; and words importing the masculine gender may be applied to females.

(2) "Act" means the Medical Practice Act of the state of Montana, 37-3-101 through 37-3-405, MCA, as amended from time to time.

(3) "Applicant" means a person who has applied for a license to practice medicine in the state of Montana, or a person who has applied to take a licensing examination.

(4) "Complainant" means a person filing a complaint.

(5) "Foreign medical graduate" means a graduate of a medical school:

(a) not located in a state or territory of the United States, or the District of Columbia; and

(b) that is listed in the World Health Directory of Medical Schools.

(6) "Intern" means a person who has graduated from an approved medical school, and is enrolled in a program of training approved for first year post-graduates. The intern may also be referred to as "in post-graduate year 1" (PGY-1), or "first year resident."

(a) An intern has passed USMLE Steps 1 and 2, and is preparing for, or awaiting the results of, USMLE Step 3, or the American osteopathic equivalent;

(b) An intern is not:

(i) yet eligible for licensure;

(ii) required to obtain a license for medical practice performed while in Montana; ~~and~~ or

(iii) ~~monitored by the board~~ subject to the board's jurisdiction.

(c) The board may extend the time of internship beyond one year for good cause shown.

(7) "Medical student" means a person currently enrolled in a school of allopathic or osteopathic medicine approved by the Council on Medical Education of the American Medical Association, the Bureau of Professional Education of the American Osteopathic Association, or the board.

(a) A medical student is not:

(i) yet eligible for licensure;

(ii) required to obtain a license for medical practice performed while in Montana; ~~and~~ or

(iii) ~~monitored by the board~~ subject to the board's jurisdiction.

(b) A person is not a medical student if the person:

(i) has been awarded a doctorate degree and successfully completed the United States Medical Licensing Examination (USMLE) Steps 1 and 2, or the equivalent level of testing by the American Osteopathic Association; or

(ii) has passed USMLE Step 3, or the equivalent level of testing by the American Osteopathic Association.

(8) "Proceeding" shall include:

(a) a formal complaint alleging violation of any provision of the act or any regulation or requirement made pursuant to a power granted by such act;

(b) a hearing before the board pursuant to the provisions of 37-3-321 through 37-3-324, MCA.

(9) "Resident" means a person who ~~is educationally eligible for~~ ~~as a~~ ~~physician~~, ~~that~~ ~~is~~:

(a) has the degree of medical doctor~~,~~ or doctor of osteopathy ~~or an equivalent degree~~ from a school approved by the Council on Medical Education of the American Medical Association or the Bureau of Professional Education of the American Osteopathic Association;

(b) has successfully completed the USMLE Steps 1 and 2 or the equivalent level of testing by the American Osteopathic Association, or where applicable, holds a certificate from the Educational Commission for Foreign Medical Graduates (ECFMG);

(c) is enrolled in a residency training program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the equivalent American Osteopathic Association credentialing body or one that meets the requirements of 24.156.508.

(~~b~~d) is~~for purposes of licensure only:~~ an educationally eligible resident may apply for a temporary resident license or a temporary rural rotation license under 24.156.617;

(e) isa resident who is expected to successfully complete a residency program within three months may apply for a physician license under 24.156.603.

(i) ~~prior to October 1, 2001, has completed post-graduate year 1; or~~

(ii) on or after ~~October 1, 2001~~, completed ~~a~~ post-graduate ~~year 2~~ program;

~~(c) holds a certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) where applicable; and~~

~~(d) is enrolled in a residency training program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the equivalent American Osteopathic Association credentialing body;~~

~~(e) a resident may apply for licensure:~~

~~(i) if the resident is enrolled in an ACGME-approved residency or a residency approved by the American Osteopathic Association, the resident need not have an existing, active license to practice as a physician in a state or territory of the United States;~~

~~(ii) if the resident is not enrolled in an ACGME-approved residency, the resident must have an existing, active license to practice as a physician in a state or territory of the United States in order to obtain resident registration.~~

(10) "Secretary" means the executive secretary of the Montana state Board of Medical Examiners.

(11) "Surgery" means any procedure in which human tissue is cut or altered by mechanical or energy forms, including electrical or laser energy or ionizing radiation.

24.156.502 MEDICAL SCHOOLS (1) Any medical schools , including foreign medical schools, which ~~has~~have not been approved by the Council on Medical Education of the American Medical Association or its successors or an equivalent organization may be approved, at the applicant's cost, upon investigation of ~~its~~ their educational standards and facilities by the Montana ~~state~~ State Board of Medical Examiners ~~at the cost of the applicant which shall include foreign medical schools~~ using any means the board determines to be feasible

24.156.503 MEDICAL STUDENT'S PERMITTED ACTIVITIES (1) All medical practice must be under the direct supervision of a Montana-licensed physician, who must be aware of and is responsible for the limitations placed on the medical student's scope of practice. ~~Either~~ Both the medical student's medical school ~~or~~ and ~~the supervising physician~~ must carry malpractice insurance covering the medical student's practice during the training process.

(2) As used herein, "direct supervision" means that the supervising physician is physically present in the same building as the medical student, or is within 20 minutes of the physical presence of the patient being cared for by the medical student.

(3) The medical student may:

(a) assist the licensed physician in medical procedures (for example, suturing wounds) in an office or hospital;

(b) scrub and assist the licensed physician in surgery;

(c) participate in educational and patient conferences; and

(d) participate in medical research.

(4) The medical student may not practice independently; ~~for example,~~ among other things, the medical student may not:

(a) perform surgery;

(b) care for a patient in an emergency room without the physical presence of the supervising physician;

(c) prescribe medications without the cosignature of the medical student's supervising physician;

(d) write or issue orders without the cosignature of the medical student's supervising physician; or

(e) sign hospital records or patient charts without the cosignature of the medical student's supervising physician.

24.156.504 INTERNSHIP (1) An internship not approved as required by 37-3-102(1), MCA, may be approved upon investigation by the board through its executive secretary ~~or some other regularly licensed physician~~ or any other representative which the board may choose, at the expense of the applicant requesting approval of the internship.

24.156.505 INTERN'S SCOPE OF PRACTICE (1) If the training program in which the intern is enrolled is approved by the ACGME, the intern's scope of practice shall be defined by the residency review committee of the ACGME, or American Osteopathic Association equivalent.

(2) If the training program in which the intern is enrolled is not approved by the ACGME or American Osteopathic Association equivalent, the intern's medical practice must be under the direct supervision of a Montana-licensed physician, who:

(a) must be aware of the statutory limitations on the intern's scope of practice; and

(b) must carry malpractice insurance covering the intern's conduct during the training process.

(3) As used herein, "direct supervision" means that the supervising physician is physically present in the same building as the intern, or is within 20 minutes of the physical presence of the patient being cared for by the intern.

(4) Subject to the local training program's requirements, the intern may:

(a) assist the licensed physician in medical procedures (office and hospital);

(b) scrub and assist the licensed physician in surgery;

(c) participate in educational and patient conferences;

(d) participate in medical research;

(e) prescribe medications~~,~~ without the cosignature of the intern's supervising physician;

(f) write or issue orders~~,~~ without the cosignature of the intern's supervising physician; and

(g) sign hospital records or patient charts~~,~~ without the cosignature of the intern's supervising physician.

(5) The intern may not practice independently; ~~for example,~~ among other things, the intern may not:

(a) perform surgery; or

(b) care for a patient in an emergency room without the physical presence of the supervising physician.

<u>24.156.507 RESIDENT'S SCOPE OF PRACTICE</u> (1) A resident may practice medicine in a hospital or clinic in which the resident is training, under the general supervision of a Montana-licensed physician.

(2) As used herein, "general supervision" means that the supervising physician need not be physically present in the same building as the resident, nor within 20 minutes of the physical presence of the patient being cared for by the resident.

(3) If the training program in which the resident is enrolled is approved by, or affiliated with a program approved by the ACGME, the resident's scope of practice shall be defined by the residency review committee of the ACGME.

(4) If the training program in which the resident is enrolled is not approved by the ACGME, the supervising physician must be aware of the statutory limitations on the resident's scope of practice, and must carry malpractice insurance covering the resident's conduct during the training process.

(5) A resident may, among other things:

(a) participate in active, actual patient care;

(b) write prescriptions and orders without cosignature of the sponsoring or supervising physician;

(c) sign hospital charts and office records;

(d) assume increasing responsibility in surgical and medical care, within the context of a review process;

(e) take emergency room and other calls independently and without direct supervision; and

(f) participate in medical research and review processes.

(6) A resident of the Montana Family Medicine Residency Program may practice medicine in a hospital or clinic not associated with the residency training program under the general supervision of a Montana licensed physician by applying for and meeting the qualifications for a temporary resident license .

(7) A resident may practice medicine in a hospital or clinic approved by their residency training program under the general supervision of a Montana licensed physician by applying for and meeting the qualifications for a temporary rural rotation resident license.

24.156.508 APPROVED RESIDENCY (1) A residency is approved for purposes of 37-3-102(3), MCA, if the training program meets the following criteria:

(a) is in a hospital or clinic located in the United States; and

(b) has been approved by the American Council on Graduate Medical Education or the American Osteopathic Association.

(2) Alternatively, a residency is approved if, upon investigation, the board finds that the residency:

(a) is approved by, or affiliated with, the World Health Organization;

(b) carries malpractice insurance;

(c) has been approved for certification by the American Board of Medical Specialties;

(d) requires residents seeking residencies in the United States to have sufficient fluency in spoken and written English to practice medicine with reasonable skill and safety;

(e) has an internal examination process (if written examinations are conducted, the residency will provide the board with reports or access to examination results); and

(f) provides that residents are supervised by a ~~mentor who:~~ licensed physician who

~~(i) is a licensed physician; and~~

~~(ii)~~ provides written evaluations and/or reports to the training program, and to the board upon request.

24.156.601 FEE SCHEDULE (1) The following fees will be charged:

(a) License application fee	$325
(b) Temporary license application fee	325
~~(c) Temporary locum tenens~~	~~50~~
(dc) Renewal fee (active)	400
(~~e~~d) Renewal fee (inactive)	200
~~(f) Renewal fee (inactive-retired)~~	~~65~~
(~~g~~e) ~~Limited~~ ~~t~~Temporary ~~(~~resident~~)~~ license application fee	100
(~~h~~f) ~~Limited~~ ~~t~~Temporary ~~(~~resident~~)~~ extension fee	50
(g) Temporary rural rotation resident license application fee	100

(2) Additional standardized fees to be charged are specified in ARM 24.101.403.

(3) All fees are nonrefundable.

24.156.603 APPLICATIONS FOR LICENSURE (1) Application forms will be provided to an applicant in accordance with the requirement of 37-3-305, MCA, and all of the requirements set forth in 37-3-101 through 37-3-405, MCA. In addition to the foregoing, the board may, in its discretion, require statements of good character and references from all ~~areas~~facilities and medical practices where the applicant has ~~previously practiced or~~ attended school, completed a residency, previously practiced, or is currently attending a post graduate residency or fellowship program. The application must be complete and accompanied by the appropriate fees and the following information and/or documentation:

(a) applicant's current original unopened National Practitioner Data Bank (NPDB) self-query report;

(b) verification of graduation from medical school or college of osteopathic medicine and surgery;

(c) verification of successful completion of postgraduate residency program:

(d) three written character references who are licensed physicians;

(e) examination results for USMLE, NBOME/COMLEX, FLEX, LMCC, or state examination;

(f) completion of Drug Enforcement Agency query;

(g) copy of DD214 military discharge, if applicable; ~~and~~

(h) certification of examination passage of Educational Council on Foreign Medical Graduates, if a foreign medical graduate; and

(i) Fifth Pathway Certificate, if applicable, for a foreign medical graduate.

(2) Applicants licensed in another state or jurisdiction shall cause all states and jurisdictions in which the applicant holds or has ever held a license to submit a current verification of licensure directly to the board on behalf of the applicant.

(3) An applicant for an active license, who is in the last three months of an approved residency program, is required to provide a letter of good standing from the approved residency program. If licensed, the applicant is required to provide the board with documentation of successful completion of the approved residency program within three months of completion.

(~~2~~4) The board may make an independent investigation of any applicant to determine whether the applicant has the qualifications necessary to be licensed, and whether the applicant has previously been guilty of any offenses which would constitute unprofessional conduct. The board may require the applicant to release any information or records pertinent to the board's investigation. The board shall require the applicant to furnish information from all states in which the applicant has previously been licensed. ~~The applicant must furnish references upon request by the board from each medical community in which the applicant has practiced.~~

(~~3~~5) An applicant who has not engaged in the active practice of medicine for the two or more years preceding his or her application ~~must~~ shall, in addition to meeting all other requirements for licensure, pass the special purpose examination given by the Federation of State Medical Boards, or its successor~~;~~ , and/or ~~may be required to~~ provide proof of competency through a program approved by the board.

(6) Applicants whose applications are received, processed, and determined to be incomplete will be sent a letter from the board office specifying the deficiencies, which may include but not be limited to appropriate fees, verifications, character references, and any other supplemental information the board or its designee deems appropriate. An incomplete application will be held for a period of one year at which time the application will be treated as an expired application and all fees will be forfeited. The applicant may correct any deficiencies and submit missing or additionally requested information or documentation necessary to complete the application within one year from the date the initial application is received in the board office.

(7) ~~The~~ An applicant who has not been asked to appear before the board may voluntarily withdraw ~~the~~ an application prior to the one-year deadline set forth in (6) by submitting a request to withdraw in writing to the board office . All application fees submitted will be forfeited.

(8) After withdrawal of an application, the applicant will be required to submit a new application, including supporting documentation and appropriate fees to begin the licensing and verification process again.

(9) Completed applications shall be reviewed by the board or its designee, which may request such additional information or clarification of information provided in the application as deemed reasonably necessary.

24.156.605 TEMPORARY LICENSE (1) Temporary licenses are entirely within the discretion of the board. ~~The application, examination and information furnished by the applicant will be carefully scrutinized to determine whether the applicant is qualified for a temporary license.~~

(2) ~~A temporary license must be reviewed and signed by one member of the board. The reviewing board member may require the applicant to attend an interview with the reviewing board member, the board or both, in the reviewing board member's discretion. A temporary license is valid until the next board meeting, at which time the board may extend it for a period up to one year.~~

(~~3~~) A temporary resident license will be issued by the board if the applicant meets the qualifications. The temporary resident license is valid for a period not to exceed one year, at which time the board may extend it for additional one year periods, not to exceed five years ~~at period up to one year~~. ~~A person shall not practice medicine in excess of three years while holding a temporary resident license.~~

(3) The granting of a temporary license does not in any way indicate that the person so licensed is necessarily eligible for regular licensure or that the board in any way is obligated to so license the person.

24.156.606 EXAMINATIONS (1) ~~Eligibility requirements for USMLE Step III are:~~

~~(a) an M.D. or D.O. degree, and~~ Applicants must pass a national examination to be qualified for licensure.

~~(b) completion, or near completion, of one year of postgraduate training in a program of graduate medical education accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, and~~

~~(c) a score of 75 or more on one of the following:~~

~~(i) National Board of Medical Examiners examination ("NBME") Parts I and II, taken before January 1, 2000; or~~

~~(ii) Federation Licensing Examination ("FLEX") Component I, taken before January 1, 2000; or~~

~~(iii) USMLE Steps I and II, and~~

~~(d) for foreign medical graduates not eligible for the fifth pathway, a score of 75 or more on ECFMG~~.

(2) ~~USMLE Step III must be taken within seven years of the applicant's first examinations under (1)(c) unless the applicant is or has been a student in a recognized M.D./Ph.D. program in a field of biological sciences tested in the Step I content. Applicants seeking an exception to the seven-year rule shall present a verifiable and rational explanation for being unable to meet the seven-year limit.~~ For exams taken after January 1, 2000, the board will accept only USMLE Steps 1, 2 and 3, passed with a score of 75 or more for each step.

(3) ~~If an applicant fails to obtain a score or 75 or more in the first attempt at USMLE Step III, the applicant may be reexamined no more than two additional times.~~

The board will accept an examination by the National Board of Examiners for Osteopathic Physicians and Surgeons, or its successor, passed with a score of 75 or more, regardless of date of examination.

(4) For exams taken prior to January 1, 2000, the board will accept the following combination of examinations passed with a score of 75 or more for each component exam, in satisfaction of the examination requirement for licensure:

(a) NBME Parts I, II and III; or

(b) NBME Part I or USMLE Step 1, plus NBME Part II or USMLE Step 2, plus NBME Part III or USMLE Step 3; or

(c) FLEX Components 1 and 2; or

(d) FLEX Component 1 plus USMLE Step 3; or

(e) NBME Part I or USMLE Step 1, plus NBME Part II or USMLE Step 2, plus FLEX Component 2.

NEW RULE I. (assign to 24.156.607): BOARD SPONSORSHIP AND ELIGIBLITY REQUIREMENTS FOR USMLE STEP III and SPECIAL PURPOSE EXAM (SPEX) (1) Board sponsorship and eligibility requirements for USMLE Step III are:

(a) an M.D. or D.O. degree, and

(b) completion or being within one month of completion of one year of postgraduate training in a program of graduate medical education accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, and

(c) a score of 75 or more on one of the following:

(i) National Board of Medical Examiners examination ("NBME") Parts I and II, taken before January 1, 2000; or

(ii) Federation Licensing Examination ("FLEX") Component I, taken before January 1, 2000; or

(iii) USMLE Steps I and II, and

(d) for foreign medical graduates not eligible for the fifth pathway, a score of 75 or more on ECFMG.

(2) USMLE Step III must be taken within seven years of the applicant's first examinations under (1)(c) unless the applicant is or has been a student in a recognized M.D./Ph.D. program in a field of biological sciences tested in the Step I content. Applicants seeking an exception to the seven-year rule shall present a verifiable and rational explanation for being unable to meet the seven-year limit.

(3) If an applicant fails to obtain a score or 75 or more in the first attempt at USMLE Step III, the applicant may be reexamined no more than two additional times.

(4) Applicants who have not practiced in more than two years prior to submitting an application for licensure shall be required to take the SPEX test. Such applicants may petition the board to sponsor them for the SPEX text by submitting a completed application and meeting with the board for full board approval.

24.156.~~607~~8 (amend rule and transfer to 24.156.608) GRADUATE TRAINING REQUIREMENTS FOR FOREIGN MEDICAL GRADUATES (1) A license will not be granted to a foreign medical graduate unless:

(a) the graduate has successfully completed an approved post graduate residency program of at least three years ~~had three years of post-graduate training education~~ in a post-graduate institution that has been approved by the Council on Medical Education of the American Medical Association or the American Osteopathic Association or successors; or

(b) the graduate has been granted board-certification by a specialty board which is approved by, and a member of, the American Board of Medical Specialties or the American Osteopathic Association~~.~~; or

(c) the graduate has successfully completed two years of post-graduate training education at the Montana Family Residency Program and is an applicant for a resident physician temporary license.

24.156.60~~8~~9 (transfer to 24.156.609) ECFMG REQUIREMENTS (1) The ECFMG requirement may be waived for graduates of Canadian medical schools if the school is approved by the Medical Council of Canada, or successors.

(2) Except as set forth in (1), a foreign medical graduate must pass the examination of the Educational Council on Foreign Medical Graduates with a score of 75 or more.

24.156.60~~9~~10 FIFTH PATHWAY PROGRAM (transfer to 24.156.610) (1) The fifth pathway program is one year of supervised clinical education or training in an educational center approved for that purpose by the American Medical Association or the American Osteopathic Association or successors.

(2) The fifth pathway program, as approved by the American Medical Association Accreditation Council for Graduate Medical Education may be accepted by the board if the applicant:

(a) is a United States citizen, and

(b) has completed, in an accredited college or university in the United States, undergraduate premedical education of the quality acceptable for matriculation in an LCME-accredited U.S. medical school, and

(c) has completed four years of didactic instruction at a medical school outside the U.S. or Canada that is listed in the World Health Directory of Medical Schools, and

(d) has completed all of the formal requirements of the foreign medical school except internship, social service or certain clinical or practice requirements of the school or government, and

(e) has attained a score satisfactory to the sponsoring medical school on a screening examination, and

(f) has passed the foreign medical graduate examination in the medical sciences, or parts I and II of the examination of the National Board of Medical Examiners ("NBME"), or Component I of the Federation Licensing Examination ("FLEX"), or Steps 1 and 2 of the United States Medical Licensing Examination ("USMLE").

(3) Suitable evidence must be provided to the board of the fifth pathway program.

24.156.615 RENEWALS (1) Renewal notices will be sent as specified in ARM 24.101.414.

(2) All licensees will renew for a period of two years.

(3) A physician actively engaged in the practice of medicine with an active license shall pay a license renewal fee. If the physician does not pay the license renewal fee and return the required renewal before the date set by ARM 24.101.413, the physician must pay the late penalty fee specified in ARM 24.101.403 in order to renew the physician's license.

(4) A physician with a permanent license not actively engaged in the practice of medicine in this state or absent from this state for a period of one or more years may renew as an inactive licensee and pay the inactive fee listed in ARM 24.156.601.

~~(5) A physician with a permanent license not engaged in the practice of medicine and who has retired from practice may renew this license as an inactive-retired licensee and pay the fee listed in ARM 24.156.601. A retired license may not be reactivated. The individual must reapply for a new original license.~~

(~~6~~ 5) The provisions of ARM 24.101.408 apply.

24.156.617 LICENSE CATEGORIES (1) If the board determines that an applicant or licensee possesses the qualifications for licensure required under Title 37, chapter 3, MCA, the board may instruct the department to issue licenses in the following categories:

(a) active license;

(b) inactive license; or

~~(c) inactive-retired license; or~~

~~(d)~~ (c) ~~limited~~ temporary ~~(~~resident~~)~~ license; or

(d) temporary rural rotation resident license.

(2) An active license is required for a physician actively practicing medicine in this state at any time during the renewal period.

(a) The term "actively practicing medicine" means the exercise of any activity or process identified in 37-3-102, MCA and includes writing prescriptions or ordering diagnostic tests.

(b) A physician with an active license engaged in an academic, administrative or clinical practice is considered to be actively practicing medicine.

(c) To renew a license on active status, a physician must pay a fee prescribed by the board, and complete the renewal prior to the date set by ARM 24.101.413.

(3) An active license is required for a physician participating in the Montana health corps.

(4) An inactive license may be obtained by a physician who is not actively practicing medicine in this state, and who does not intend to actively practice medicine in this state at any time during the current renewal period, but may wish to reactivate in the next renewal period.

(a) A physician with an inactive license cannot actively practice medicine or write prescriptions or order diagnostic tests.

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~~(a)~~ (b) To renew a license on inactive status, a physician must pay a fee prescribed by the board, and complete the renewal prior to the date set by ARM 24.101.413.

(c) A physician with an inactive license who does not practice medicine in Montana or any other jurisdiction during the two year term of the inactive license and wants to change to an active license may shall be required to pass the SPEX, and/or provide proof of competency through a program approved by the board.

(5) An inactive-retired license may be obtained by an applicant or licensed physician who is not actively practicing medicine in this state and does not intend ever to practice medicine in this state in the future. A physician who holds an inactive-retired license may not renew the inactive-retired license after January 1, 2012.

(a) An inactive-retired license must be renewed by the renewal date set in ARM 24.101.413. The inactive-retired license will be expired on March 31, 2012.

(b) If both the renewal fee and completed renewal are not returned prior to the date specified in ARM 24.101.413, the physician must pay the late penalty fee specified in ARM 24.101.403 in order to renew the license. A physician may not reactivate an expired inactive-retired license and must reapply for a new license.

(6) A limited temporary resident license is required for a physician who is a graduate of a medical school or college of osteopathic medicine and surgery, has successfully completed two years of residency, is serving as a third year resident in the Montana Family Medicine Residency Program and plans to otherwise engage in the practice of medicine. The license shall be designated a Temporary Resident License.

(a) A temporary resident license authorizes the licensee to serve as a resident physician only, under the supervision of a licensed physician in the state of Montana.

(b) A temporary resident license shall be effective for one year and may be extended for an additional one year periods for an additional fee.

(7) A temporary rural rotation resident license is required for a physician who is a graduate of a medical school or college of osteopathic medicine and surgery, and will be serving as resident in a rural rotation. The license shall be designated a Temporary Rural Rotation Resident License.

(a) a temporary rural rotation resident license authorizes the licensee to serve as a resident physician only, under the supervision of a licensed physician in the state of Montana, and as part of an approved residency program.

(b) a temporary rural rotation temporary license shall be effective for one year and may not be extended.

NEW RULE II: OBLIGATION TO REPORT TO BOARD (1) A physician shall report to the board within three months from the date of a final judgment, order, or agency action, all information related to malpractice, misconduct, criminal, or disciplinary action in which the physician is a named party.

(2) A physician shall report to the board the termination of a supervision agreement within thirty days from the effective date of the termination.

(3) A physician with suspected or known impairment shall self-report to the board. In lieu of reporting to the board, the physician may self-report to the board-endorsed professional assistance program.

(4) A physician is obligated to report suspected or known impairment of other health care providers to the appropriate licensing board, agency, or in lieu of the board or agency, may report to the endorsed professional assistance program.

Administrative rule changes for EMTs. Items underlined are amendments to current rule and the text struck out signifies deletion from current rule text. New rule proposals are at the end of this document and are assigned a rule later in the process by board counsel.

24.156.2701 DEFINITIONS For purposes of the rules set forth in this subchapter, the following definitions apply:

(1) "Advanced life support" or "ALS" means any provider that functions at any endorsement level above EMT-B.

(2) "Approved course" means a course of initial instruction that meets the specifications and requirements for a particular level ~~or endorsement for~~ of EMT training approved by the board or its designee.

(3) "Approved program" means a multiple of approved courses offered by an entity and approved by the board or its designee.

(4) "Basic life support" or "BLS" means any provider that functions at the endorsement level of:

(a) EMT-F;

(b) EMT-F with any endorsements; or

(c) EMT-B without any endorsements.

(5) "Board" means the Board of Medical Examiners.

(6) "Clinical experience" means supervised instruction, observation, and practice in a patient care setting as part of an approved course or program.

(7) "Clinical preceptor" means an individual trained to a level greater than the student, who is responsible for supervising and teaching the student in a clinical setting in an approved course or program under the supervision of the medical director or lead instructor in the case of an EMT-basic course.

(8) "Curriculum" means the combination of instructor lesson plans, course guides, and student study guides prepared by the United States Department of Transportation (USDOT) and commonly known as the "National Standard Curriculum" (NSC).

(9) "Emergency medical service" or "EMS" means out of hospital care and transportation furnished by a combination of persons licensed by the board and resources that are licensed by the Department of Public Health and Human Services pursuant to Title 50, chapter 6, MCA.

(10) "Emergency medical technician" or "EMT" means any out of hospital emergency care personnel licensed by the board.

(11) "Emergency medical technician - basic" or "EMT-B" means an individual who is licensed by the board as an EMT-B.

(12) "Emergency medical technician - first responder" or "EMT-F" means an individual who is licensed by the board as an EMT-F.

(13) "Emergency medical technician - intermediate" or "EMT-I" means an individual who is licensed by the board as an EMT-I.

(14) "Emergency medical technician - paramedic" or "EMT-P" means an individual who is licensed by the board as an EMT-P.

(15) “Endorsement” means a defined set of skills and knowledge that expands the scope of practice of the EMT. The medical director grants permission for an EMT to utilize an endorsement provided that the specific endorsement is identified on the EMT’s license~~ure~~.

(~~15~~16) "Lead instructor" means a person who is licensed by the board and authorized to offer and conduct EMT courses. The lead instructor is under the supervision of the board for BLS courses and under the supervision of the medical director for ALS courses.

(~~16~~ 17) "Medical director" means an unrestricted Montana licensed physician or physician assistant who is responsible professionally and legally for providing medical direction and oversight to a licensed EMT and/or for the training provided in an approved program/course.

(~~17~~18) "NPDB" means the National Practitioner Databank established by Public Law 99-660 (42 USC 11101, et seq.).

(~~18~~19) "NREMT" means the National Registry of Emergency Medical Technicians, an independent, not-for-profit, nongovernmental certification agency based in Columbus, Ohio.

(20) “Offline medical direction” means medical oversight and supervision for an emergency medical service or an emergency medical technician, and review of patient care techniques, emergency medical service procedures, and quality of care from a licensed physician or physician assistant in Montana.

(~~19~~21) "~~On-line~~ Online medical direction" means real-time interactive medical direction, advice, or orders to EMTs from an unrestricted Montana licensed physician or physician assistant ~~who is supervised by the medical director~~.

(~~20~~22) "Statewide protocols" means a written, standardized manner of administering patient care statewide, approved by the board.

24.156.2705 UNPROFESSIONAL CONDUCT (1) In addition to those forms of unprofessional conduct defined in 37-1-316, MCA, the following are considered unprofessional conduct for a licensee or license applicant under Title 50, chapter 6, part 2, MCA:

(a) conviction, including conviction following a plea of nolo contendere, of an offense involving moral turpitude, whether a misdemeanor or felony, and whether or not an appeal is pending;

(b) conduct likely to deceive, defraud, or harm the public including but not limited to practicing while subject to a physical or mental condition which renders the licensee unable to safely engage in activities required of a licensee under this subchapter;

(c) acting in such a manner as to present a danger to public health or safety, or to any patient including but not limited to incompetence, negligence, or malpractice;

(d) making a false or misleading statement regarding the licensee's skill in connection with the activities required of a licensee under this subchapter;

(e) use of a false, fraudulent, or deceptive statement, whether written or verbal, in connection with the activities required of a licensee under this subchapter;

(f) having been subject to disciplinary action of another state or jurisdiction against a license or other authorization, based upon acts or conduct by the licensee similar to acts or conduct that would constitute grounds for disciplinary action under Title 37, chapter 1, MCA, or rules under this subchapter. A report from the NPDB or a certified copy of the record of the action taken by the other state or jurisdiction is evidence of unprofessional conduct;

(g) having voluntarily relinquished or surrendered a professional or occupational license, certificate, or registration in this state, or in another state or jurisdiction;

(h) having withdrawn an application for licensure, certification, or registration, while under investigation or prior to a determination of the completed application in this state, or in another state or jurisdiction;

(i) failure to practice within the scope of practice of the EMT level and endorsements;

(j) failure to practice within adopted statewide and/or local protocols, policies, and procedures established and approved by the board and medical director;

(k) failing to maintain continuous NREMT registration while licensed as an EMT in the state of Montana;

(l) willful disobedience of the provisions of Title 37, chapter 1, MCA, any rule adopted by the board, or any order of the board regarding enforcement of discipline of a licensee;

(m) habitual intemperance or excessive use of an addictive drug, alcohol, or any other substance to the extent that the use impairs the user physically or mentally; this provision does not apply to a licensee who is in compliance with an approved therapeutic regimen as described in 37-3-203, MCA;

(n) failing to furnish to the board or its designee information requested by the board or a response to an inquiry;

(o) failing to cooperate with a lawful investigation conducted by the board;

(p) failing to comply with any statute or rule under the Board of Medical Examiner's jurisdiction;

(q) filing a complaint with, or providing information to, the board which the licensee knows, or ought to know, is false or misleading. This provision does not apply to any filing of complaint or providing information to the board when done in good faith under 37-1-308, MCA;

(r) failing to report to the board any adverse judgment or award arising from a medical liability claim or other unprofessional conduct;

(s) commission of any act of sexual abuse, misconduct, or exploitation by the licensee whether or not related to the practice;

(t) failing to exercise technical competence in carrying out EMT care;

(u) testifying in a legal proceeding on a contingency fee basis;

(v) falsifying and altering patient records or trip reports, intentionally documenting patient records or trip reports incorrectly, failing to document patient records, or prepare trip reports;

(w) diversion of a medication for any purpose or a violation of state or federal laws governing the administration of medications;

(x) failing, as a clinical preceptor or lead instructor, to supervise, manage, or train students practicing under the licensee's supervision, according to:

(i) scope of practice;

(ii) generally accepted standards of patient care;

(iii) board-approved USDOT curriculum including revisions; and

(iv) statewide protocols, policies, and procedures.

(y) willfully harassing, abusing, or intimidating a patient, either physically or verbally;

(z) practicing as an EMT at any level without a current, active Montana license at that level;

(aa) failing to comply with any agreement the licensee has entered into with a program established by the board under 37-3-203, MCA; ~~and~~

(ab) any other act, whether specifically enumerated or not that in fact constitutes unprofessional conduct; and

(ac) failing to report to the board unprofessional conduct of other licensed EMT's.

24.156.2711 EMT-LICENSURE QUALIFICATIONS (1) The board shall license an applicant as an EMT at the appropriate level, if the applicant:

(a) successfully completes a board approved EMT course of instruction;

(b) possesses current NREMT registration for the appropriate level of licensure or higher~~, except for EMT-Fs who have maintained continuous licensure prior to January 1, 2004~~;

(c) provides all the information necessary to establish eligibility for licensure according to the licensure requirements as specified by the board or its designee;

(d) possesses a high school diploma or equivalency; and

(e) is 18 years of age or older.

24.156.2713 EMT LICENSE APPLICATION (1) An applicant for an EMT license, at any level, shall submit an application on a form prescribed by the board. The application must be complete and accompanied by the appropriate fees and the following documentation:

(a) applicant's verification of course completion for the appropriate level ~~and/or endorsement levels~~ for which the applicant is applying;

(b) proof the applicant possesses a high school diploma or its equivalent;

(c) a copy of the applicant's birth certificate or other verifiable evidence of the applicant's date of birth, such as a driver's license;

(d) a current NREMT registration card equal to or greater than the level for which the applicant is applying; and

(e) an unopened, current and original NPDB self-query.

(2) Applicants licensed in another state or jurisdiction shall cause all states and jurisdictions in which the applicant holds or has ever held a license to submit a current verification of licensure directly to the board on behalf of the applicant.

(~~2~~3) Incomplete applications will be returned. The applicant may correct any deficiencies, complete any requirements necessary for licensure, and resubmit the application to the board office. Failure to resubmit the deficient application within one year from the date of the original submission will be treated as a voluntary withdrawal of the application and all fees will be forfeited.

(~~3~~4) The applicant may voluntarily withdraw the application prior to the one-year deadline set forth in (~~2~~3) by submitting a withdrawal in writing to the board. All application fees submitted will be forfeited.

(~~4~~5) After withdrawal of an application, the applicant will be required to submit a new application, including supporting documentation and appropriate fees to begin the licensing and verification process.

(~~5~~6) Completed applications will be reviewed by the board or its designee, which may request such additional information or clarification of information provided in the application as it deems reasonably necessary.

24.156.2715 EQUIVALENT EDUCATION (1) In order for the board to recommend to the NREMT successful course completion, the course for an individual must have been either:

(a) an EMT educational program reviewed and approved by the board; or

(b) determined to be "substantially equivalent" as defined by the board. ~~The individual requesting review of their educational program must possess a currently active EMT license or certification to practice in good standing in another state.~~

(2) For the purposes of 37-1-304, MCA, the board defines "substantially equivalent" as ~~approved~~ training ~~in accordance with~~ greater than or equivalent to board-approved USDOT curriculum standards including revisions and statewide protocols, policies, and procedures ~~or, in the opinion of the board, completed training, experience, and passage of an examination equivalent to current board standards~~. Work experience obtained in the profession will not be considered as the sole basis of the applicant's qualifications.

24.156.2717 EMT LICENSE RENEWAL (1) Renewal notices will be sent as specified in ARM 24.101.414.

(2) EMT licenses are issued on a biennial renewal cycle. EMT licenses must be renewed on or before the date set by ARM 24.101.413 of the last year of the two-year cycle.

(3) Except as provided in (4), in order to renew an EMT license, the licensee must:

(a) submit a license renewal application on a form or through electronic means prescribed and supplied by the board;

(b) ~~submit~~ maintain current NREMT registration at the level equal to or greater than the licensed level; and

(c) submit payment of the renewal fee set in ARM 24.156.2731.

(4) An individual licensed prior to January 1, 2004, as a first responder or first responder ambulance, and wishing to renew the license as an EMT-F, may either:

(a) become NREMT registered; or

(b) complete a ~~16-hour board-approved~~ USDOT First Responder curriculum refresher course each renewal period. The licensee shall provide verification of completion to the board upon request.

(5) Incomplete renewal applications will be returned to the licensee and will not be considered received by the board.

(6) The provisions of ARM 24.101.408 apply.

24.156.2719 EXPIRED LICENSE (1) An expired EMT license may be reactivated upon completion of an expired license renewal application. To reactivate an expired license the applicant shall:

(a) complete an expired license renewal application and submit it to the board;

(b) pay the license fee plus late penalty fee as specified in ARM 24.101.403 for each year the license has expired up to two years; and

~~(c) submit a current NREMT certification~~ hold a current NREMT certification.

(2) The provisions of ARM 24.101.408 apply.

24.156.2732 MEDICAL DIRECTION (1) ~~Effective June 30, 2009 and within~~ Within six months of taking on the responsibilities as an EMT ~~off-line~~ medical director, a physician or physician assistant shall:

(a) notify the board they are providing medical direction to EMTs;

(~~a~~b) provide proof of completion of ~~complete a~~ board specified training program or board approved exemption from the training~~;~~.

~~(c) demonstrate the principals of medical direction; or~~

~~(d) receive approval from the board in the event that (1)(a) or (b) is not available in that six month period.~~

(2) A physician or physician assistant who functions as a medical director and fails to comply with the requirements of (1) may not function as a medical director.

(3) The ~~off-line~~ medical director shall be responsible for the overall medical care provided by EMTs for whom the director agrees to provide medical oversight.

(4) The ~~off-line~~ medical director must assure and have access to records of all EMTs for whom the director provides medical oversight. These records must include but are not limited to:

(a) the name, address, and current Montana licensure of the EMT including any endorsements;

(b) date when medical oversight began and at what level the EMT is authorized to function; and

(c) any changes to limit or approve the EMT's ability to function at the EMT's current licensure level.

(5) The ~~off-line~~ medical director must develop a process to assure continued appropriate patient care. This process may include regular review of patient care reports (PCR), direct observation of care, skills demonstrations, and ongoing involvement in EMT education. Documentation of these activities must be maintained.

(6) A~~n~~ ~~off-line~~ medical director may assign duties where appropriate but retains the responsibility for all assigned duties.

(7) The medical director approves and supervises the offering of offline or online medical direction.

(~~7~~8) The ~~off-line~~ medical director may cease medical oversight by providing written notice to the EMT and the board.

24.156.2741 EMT TRAINING PROGRAM/COURSE APPLICATION AND APPROVAL

(1) An individual, corporation, partnership, or any other organization may not initiate or conduct any initial courses for EMT instruction without prior approval of the board or its designee.

(2) Program or course approval applications must be submitted on a form prescribed by the board with appropriate fees.

(a) The application must designate a ~~medical director and~~ lead instructor. An application for an ALS course or program must also designate a medical director.

(b) Applicants applying for ~~the~~ approval of a program must complete and submit a board approved self study for BLS and ALS, as applicable, with the application.

(3) Completed applications will be reviewed for compliance with board statutes, rules, board-approved USDOT curriculum including revisions and statewide protocols, policies, and procedures. The board or its designee may request such additional information or clarification of information provided in the application as it deems reasonably necessary.

(4) Incomplete applications will be returned. The medical director and/or lead instructor may correct any deficiencies, complete any requirements necessary for course or program approval at the level applied for, and resubmit the application to the board. Failure to resubmit the application within one year will be treated as a voluntary withdrawal of the application and all fees will be forfeited.

(5) The medical director and/or lead instructor may voluntarily withdraw the course or program approval application prior to the one-year deadline provided in (4), by writing to the board. All fees submitted will be forfeited.

(6) After withdrawal of an application, a new program or course approval application may be submitted including all supporting documentation and appropriate fees to begin the course approval process.

(7) The board or its designee shall approve EMT training courses or programs that comply with current board-approved USDOT curriculum including revisions and statewide protocols, policies, and procedures.

(a) Program approvals of multiple courses offered by a single provider may be approved for up to one year without reapplication and approval.

(b) Single courses must be approved on an individual basis.

(8) The board shall not approve an EMT training course or program which does not comply with current board-approved USDOT curriculum including revisions and statewide protocols, policies, and procedures.

(a) The board shall provide in writing the reason for course denial to the course applicant.

(b) The board may cancel approval of training courses or programs for failure to comply with any of the requirements of this subchapter, providing false information, or failure to provide the board or its designee access to the course and/or other information necessary to assure compliance with board statutes and rules.

(9) In the event the board's designee disapproves an EMT training course or program, the application will be considered by the board during the next regularly scheduled board meeting or the lead instructor and/or medical director may request in writing an alternate regularly scheduled board meeting.

(10) A lead instructor may conduct required EMT refresher courses without preapproval from the board. The lead instructor must maintain all course records, demonstrating that NSC had been utilized and student performance is documented. All course records shall be made available for auditing purposes.

(11) An approved program application is not renewable.

24.156.2745 EXAMINATIONS (1) All practical examinations for all basic EMT licensure levels ~~and endorsements~~ must be conducted in accordance with the policies and procedures established by the board. ALS examinations must be approved by the board and conducted in accordance with NREMT policies and procedures.

(2) A medical director shall be responsible for the conduct of all locally administered examinations and shall assure that all board policies and procedures are followed. Medical directors may delegate duties where appropriate.

(3) Practical examinations ~~materials~~ must be ~~requested from~~ approved by the board on forms prescribed by the board no later than ~~30~~ 20 days prior to offering an examination. ~~Examination materials will be sent to the requestor from the board office seven days prior to the scheduled examination date. The~~ BLS post examination materials shall be returned within seven working days following the examination.

(4) The board or its designee may attend and audit all exams requested and offered.

(5) No candidate may sit for a practical examination without having demonstrated successful course completion at the level of the examination or greater.

24.156.2754 INITIAL EMT COURSE REQUIREMENTS (1) All courses and courses within a program for EMT licensure levels ~~and endorsements~~ must be conducted in accordance with the policies and procedures established by the board.

(2) An EMT-F course shall be managed by a lead instructor. The lead instructor shall maintain overall responsibility for the quality, consistency, and management of the course. The lead instructor shall:

(a) conduct the EMT-F courses in accordance with current board-approved USDOT curriculum including revisions and statewide protocols, policies, and procedures;

(b) document student skill proficiency on forms prescribed and supplied by the board;

(c) complete the course within six months of the date the course commences; and

(d) provide at least one instructor per six students when practical skills are taught.

(3) An EMT-B course shall be managed by a lead instructor. The lead instructor shall maintain overall responsibility for the quality, consistency, and management of the course. The lead instructor shall:

(a) conduct the EMT-B courses in accordance with current board-approved USDOT curriculum including revisions and statewide protocols, policies, and procedures;

(b) document student skill proficiency on forms prescribed and supplied by the board;

(c) complete the course within 12 months of the date the course commences;

(d) provide at least one instructor per six students when practical skills are taught;

(e) provide a minimum of ten hours of clinical experience with an EMS or in a local patient care setting; and

(f) have a medical director involved in either the course development, presentation, or evaluation.

(4) An EMT-I or EMT-P course shall be managed by a lead instructor under the supervision of a medical director. The lead instructor and medical director shall maintain overall responsibility for the quality, consistency, and management of the course. The lead instructor and medical director shall:

(a) conduct the EMT-I and EMT-P courses in accordance with current board-approved USDOT curriculum including revisions and statewide protocols, policies, and procedures;

(b) document student skill proficiency on forms prescribed and supplied by the board;

(c) provide clinical experience as specified in the approved curriculum and in accordance with this subchapter; and

(d) provide that the course is completed as follows:

(i) the EMT-I course, within 18 months from the starting date of course; and

(ii) the EMT-P course, within 24 months from the starting date of course.

(e) provide clinical experiences with no fewer than one clinical preceptor for every two students;

(f) provide a sufficient patient volume to allow students to complete all clinical experiences within the course dates;

(g) provide EMT-I course clinical facilities that include but are not limited to:

(i) an emergency department with physician staffing;

(ii) intensive care beds or coronary care beds; and

(iii) an EMS operating at a level equal to or greater than the EMT-I level; and

(h) provide for the EMT-P course clinical facilities that include but are not limited to:

(i) an emergency department with physician staffing;

(ii) intensive care beds or coronary care beds;

(iii) operating/recovery room;

(iv) pediatric beds;

(v) labor/delivery room/newborn nursery;

(vi) psychiatric beds;

(vii) morgue;

(viii) radiology department;

(ix) respiratory therapy department; and

(x) an EMS operating at a level equal to the EMT-P level.

24.156.2757 EMT CLINICAL REQUIREMENTS (1) Clinical opportunities for students must be coordinated with the course/program and the clinical facility. Prior to course or program approval ~~T~~there must be a written ~~contractual~~ agreement in place between the course/program and the clinical facility or local medical director ~~prior to the student being allowed to function in the clinical facility~~.

(2) EMT-B programs must assure that the student completes a minimum of ten hours of observational time with an EMS. An alternative patient care setting may be used if an EMS is not available. During this time the student shall complete and document:

(a) at least five patient contacts during which the student can observe patient care; and

(b) at least five patient contacts in which the student conducts a patient assessment.

(3) EMT-I and EMT-P programs must assure that the student completes and documents, as a minimum, the clinical contact requirements identified in the board-approved USDOT curriculum including revisions and statewide protocols, policies, and procedures.

24.156.2771 SCOPE OF PRACTICE (1) An EMT licensed or endorsed at the BLS level may perform any acts allowed within the EMT's licensure or endorsement level when:

(a) operating within the most current version of the Montana statewide EMT protocols;

(b) under the medical oversight from a medical director who is taking responsibility for the EMT; or

(c) participating in a continuing education program.

(2) An EMT licensed or endorsed at the ALS level may perform any acts allowed within the EMT's licensure level or endorsement level when:

(a) under medical oversight from a medical director who is taking responsibility for the EMT;

(b) operating on a Montana licensed EMS with a medical director; or

(c) participating in a continuing education program.

(3) An EMT may perform beyond the level of the EMT's individual licensure when functioning as a student in an approved course and under the direct observation of a clinical preceptor. The EMT must perform within the acts allowed at the level for which the EMT is a student candidate.

(4) Except as provided in (3), an EMT may not perform any acts that are beyond the EMT's level of licensure or endorsement.

(5) The medical director may limit the functioning scope of an EMT due to community needs and/or issues with maintaining competency. If ~~the medical director~~ after remediation and review of an individual EMT's performance, the medical director has continuing concerns as to ~~their~~ the EMT's ability to perform the EMT's scope of practice, this shall be reported to the Board.

(~~5~~6) An EMT currently licensed and in good standing in another state may function during a state and/or federally managed incident under the Montana statewide protocols, policies, and procedures but shall comply with all of the following:

(a) limit the EMT's practice to the duration of the state and/or federally managed incident;

(b) practice within the geographic area, whether on federal, state, or private land, designated as being within the state and/or federally managed incident;

(c) practice at the basic level, even if the EMT is licensed at a higher level in another state, unless the individual is licensed at an EMT-I or EMT-P level, and the federally managed incident has medical control provided by a Montana licensed physician, and the physician authorizes the individual to function beyond the basic level;

(d) provide proof of current licensure and good standing in another state; and

(e) submit the appropriate form to the board.

(~~6~~7) In the event of ~~a bioterrorism attack~~ an emergency response in which chemical agents are used or suspected as being used, EMTs at all levels who are appropriately trained are authorized by the board to carry antidote auto-injector~~s~~ kits and administer them as instructed to themselves and any others. Instruction in the use of antidote kits is required in all EMT initial and refresher courses.

24.156.2775 MANAGEMENT OF INFECTIOUS WASTES (1) Each EMT licensed by the board shall store, transport off the premises, and dispose of infectious wastes, as defined in 75-10-1003, MCA, in accordance with the requirements set forth in 75-10-1005, MCA.

(2) Used sharps shall be properly packaged and labeled within the meaning of 75-10-1005, MCA, as required by the Occupational Safety and Health Administration (OSHA). ~~If~~

~~OSHA has no such requirements, the EMT shall place used sharps in a heavy, leak proof, puncture-resistant container and secure the lid with reinforced strapping tape. The container shall bear the words "used medical sharps" on a distinctive label taped or securely glued on the container~~.

NEW EMT RULES

NEW RULE I. EMT ENDORSEMENT APPLICATION (1) An applicant for an EMT endorsement at any level, shall submit an application on a form prescribed by the board. The application must be complete and accompanied by the appropriate fee and the following documentation.

(a) applicant's verification of knowledge and skills as identified on a form provided by the board for each endorsement level for which the applicant is applying.

(2) An applicant for an EMT endorsement must have an EMT license in Montana at the appropriate level.

(3) Incomplete applications will be returned. The applicant may correct any deficiencies, complete any requirements necessary and resubmit the application to the board office. Failure to resubmit the deficient application within one year from the date of the original submission will be treated as a voluntary withdrawal of the application and all fees will be forfeited.

(4) The applicant may voluntarily withdraw the application prior to the one-year deadline set forth in (3) by submitting a withdrawal in writing to the board. All application fees submitted will be forfeited.

(5) After withdrawal of an application, the applicant will be required to submit a new application, including supporting documentation and appropriate fees to begin the endorsement and verification process.

(6) Completed applications will be reviewed by the board or its designee, which may request such additional information or clarification of information provided in the application as it deems reasonably necessary.

NEW RULE II. OBLIGATION TO REPORT TO THE BOARD (1) As permitted in 37-1-308 an EMT licensed under this chapter shall report to the board within three months from the date of a final judgment, order, or agency action, all information related to malpractice, misconduct, criminal, or disciplinary action in which the EMT is a named party.

(2) An EMT with suspected or known impairment shall self-report to the board. In lieu of reporting to the board, the EMT may self-report to the board-endorsed professional assistance program.

(3) An EMT is obligated to report suspected or known impairment of other health care providers to the appropriate licensing board, agency, or in lieu of the board or agency, may report to the endorsed professional assistance program.

NEW RULE III. EMT TRAINING PROGRAM/COURSE POST COURSE REQUIREMENTS (1) Approved courses and programs must provide to the board a written report within 10 days of the completion of the course.

(a) The report must contain the names of students enrolled at the start of the course or program, and state their status at the end of the course to indicate if the student passed, failed, dropped or did not complete the course.

(b) Program reports must contain the type of course offered.

(c) Course reports must include a final agenda that reflects the actual course offering, including dates, instructors and topics taught.

(2) Approved programs must provide to the board a written summary report by January 31st of the year following the dated the program was approved. The report shall at a minimum contain:

(a) a breakdown of level and type of course(s) offered;

(b) the numbers of students accepted into the course(s) and resulting status at the end of the course to indicate numbers of students who passed, failed, dropped or did not complete the course.

(c) the passage and failure rates of the NREMT examination; and

(d) copies of certificates issued to the students by the program.

NEW RULE IV. COMPLAINTS INVOLVING PREHOSPITAL CARE, INTERFACILITY CARE, EMERGENCY MEDICAL TECHNICIANS OR EMERGENCY MEDICAL SERVICE (EMS) OPERATIONS (1) If the board receives a written complaint or otherwise obtains information that an EMT licensee, EMT license applicant, or EMS may have committed a violation of the established patient care standards for prehospital and interfacility emergency medical treatment and transportation or is in violation of applicable rules and statutes, the complaint will be reviewed by the screening panel to determine whether the complaint involves an EMT only, an EMS only, or a combination.

(2) Complaints found to involve EMS operations only will be referred to the Department of Public Health and Human Services for investigation.

(a) If the Department of Public Health and Human Services notifies the screening panel that an EMT may have violated a board rule or the practices of an EMT may be jeopardizing patient care, the screening panel will open a complaint against the EMT.

(3) Complaints found to involve an EMT will be reviewed by the board's screening panel to determine if there is reasonable cause to believe a violation was committed by following the Department of Labor and Industry's complaint process.

(a) The screening panel may request an investigation by the Department of Labor and Industry to determine whether there is reasonable cause to believe that the license or license applicant has committed the violation.

(b) If a complaint involves patient care by an EMT, the screening panel will provide to the Department of Public Health and Human Services:

(i) the complaint information and the screening panel's initial findings;
(ii) any potential violation of DPHHS rules;
(iii) if the existing policies or practices of EMS may be jeopardizing patient care;
(iv) information on the resolution of complaint, including any sanctions imposed against an EMT licensee.

(4) If both the screening panel and the Department of Public Health and Human Services find that an investigation is needed, a joint investigation may be conducted.

(5) Unlicensed practice complaints involving an EMT or complaints involving a new EMT applicant will be reviewed by the full board.

Proposed Rules Draft: Licensee Reporting Obligations 5/6/2011

rule amendment to PA rules:

24.156.1621 OBLIGATION TO REPORT TO BOARD (1) A physician assistant shall report to the board within three months from the date of a final judgment, order, or agency action, all information related to malpractice, misconduct, criminal, or disciplinary action in which the physician assistant or the physician assistant's supervisor, based on the physician assistant's conduct, is a named party.

(2) A physician assistant shall report to the board the termination of a supervision agreement within thirty days from the effective date of the termination.

(~~2~~ 3) A physician assistant shall, within ten days of receipt of a complaint from the board, provide the board with the name of the supervising physician who is responsible under the supervision agreement to which the complaint is related.

(~~3~~4) A physician assistant with suspected or known impairment shall self-report to the board. In lieu of reporting to the board, the physician assistant may self-report to the board-endorsed professional assistance program.

(~~4~~5) A physician assistant is obligated to report suspected or known impairment of other health care providers to the appropriate licensing board, agency, or in lieu of the board or agency, may report to the endorsed professional assistance program.

New rules for telemedicine physicians:

NEW RULE: OBLIGATION TO REPORT TO BOARD (1) A telemedicine ~~physician~~, with a telemedicine license shall report to the board within three months from the date of a final judgment, order, or agency action, all information related to malpractice, misconduct, criminal, or disciplinary action in which the physician is a named party.

(2) A telemedicine physician with suspected or known impairment shall self-report to the board. In lieu of reporting to the board, the physician may self-report to the board-endorsed professional assistance program.

(3) A telemedicine physician is obligated to report suspected or known impairment of other health care providers to the appropriate licensing board, agency, or in lieu of the board or agency, may report to the endorsed professional assistance program.

New rule for podiatrists:

NEW RULE: OBLIGATION TO REPORT TO BOARD (1) A podiatrist shall report to the board within three months from the date of a final judgment, order, or agency action, all information related to malpractice, misconduct, criminal, or disciplinary action in which the physician is a named party.

(2) A podiatrist with suspected or known impairment shall self-report to the board. In lieu of reporting to the board, the physician may self-report to the board-endorsed professional assistance program.

(3) A podiatrist is obligated to report suspected or known impairment of other health care providers to the appropriate licensing board, agency, or in lieu of the board or agency, may report to the endorsed professional assistance program.

Note: Acupuncture and Nutritionist rules have already been modified to reflect the above obligations. Rule changes proposed for physicians and EMTs include this language.

STATEMENT ON PHYSICIAN PRESCRIBING OR ORDERING DIAGNOSTIC STUDIES FOR SELF OR MEMBERS OF THE PHYSICIAN'S IMMEDIATE FAMILY

The Montana Board of Medical Examiners has been asked on numerous occasions whether it is illegal or unethical for a Montana physician to prescribe medications (whether controlled substances or uncontrolled legend drugs) for the physician's own use, or for the use of an immediate family member. Similar questions have been asked about the ordering of diagnostic studies. To clarify the Board's position on this issue, the Board offers the following observations.

There is no existing statute or rule, which specifically prohibits a physician from prescribing legend or controlled substances for members of the physician's immediate family or the physician's use, regardless of circumstances.[1] The Board of Medical Examiners does however, inquire into some cases where a physician is prescribing for him- or herself, or close family members. There are several reasons for this:

(1) Prescribing of controlled substances for a family member may be indicative of diversion to the physician's own use, in support of an addictive disorder. Such cases may be referred to the confidential Montana Professional Assistance Program, or may result in a formal, public disciplinary proceedings involving probation, suspension or revocation of the physician's medical license.

(2) In other confidential investigations, the Board has found that physician's objectivity is not at its best when prescribing for self or a close family member, and errors of judgment are made. In at least one case of prescribing for a family member, the physician was evaluated, undertook a rehabilitation program, and entered into a contract with the Montana Professional Assistance Program, while the physician's spouse underwent chemical dependency treatment. The Board would contend that close family members deserve the same objectivity and good medical judgment that the physician would extend to other members of the public. Accordingly, when a physician prescribes for a close family member, there may be grounds, under the Medical Practice Act for disciplinary action based on "failure to meet standard of care"[2] or "conduct likely to harm the public."[3] The Board is sensitive to those possibilities, especially when the physician is prescribing controlled substances on a long-term basis.

(3) Consider also the physician who begins prescribing for a family member for a condition outside the physician's own specialty, as a favor – a temporary stop-gap intended to tide the patient over until the patient's primary physician was available. The temporary prescribing stretches into long-term prescribing of controlled substances, without the physician ever performing an appropriate workup on the patient's illness, or preparing appropriate medical

[1] One section of Montana Code Annotated defines "unprofessional conduct" as "conduct that does not meet the generally accepted standards of practice." Mont. Code Ann. Section 37-1-316. Arguably, prescribing for oneself or a close family member does not meet the generally accepted standards of practice, and is therefore unprofessional conduct which may subject the physician to license discipline.

[2] Mont. Code Ann., Section 37-1-316(18)

[3] ". . . [The following is unprofessional conduct . . . : (3) Conduct likely to . . . harm the public; . . . " Administrative rules of Montana, 24.156.625(1)(c)

records.[4] When the Drug Enforcement Agency demands the physician produce the medical record required for controlled substance prescriptions, the physician is unable to do so. He or she has no effective defense against allegations of both "records violations" and "failing to meet the generally accepted standards of care." Without appropriate documentation of one's medical reasoning and management in a particular case, a physician is at significant disadvantage when the adverse expert witness testifies to a jury or licensing board, "If it wasn't charted, it wasn't done." [5]

The harm to the patient who may become physically or psychologically dependent on the controlled substances – while the underlying condition is ignored – is obvious; that is where the Board of Medical Examiners, with its obligation to protect the public,[6] enters the picture.

To answer some specific questions:

1. Q. Does the Board of Medical examiners question or investigate prescriptions for a family member, or self prescribed medication. What questions does the Board ask?

   A. Among the questions that could be asked are: Is this physician diverting to his or her own use? Is the treatment well-reasoned and well-documented? Is there a chemical dependency problem here, either in the physician or the family member? Is the physician's judgment objective and unaffected by the familial relationship? If so, will it remain so if the patient's illness progresses? Have appropriate referrals been made? Have other alternatives been tried?

2. Q. "Is it illegal or illicit for me to be prescribing controlled substances for my spouse?"

   A. No, not under current Montana law.[7] Counter questions the physician should consider, however, include: "Even though it is not illegal, is it wise?" "Is it possible the risks to the patient <u>and</u> the physician outweigh the benefits?

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[4] The decision to treat a family member should include careful evaluation of the complexity and chronicity of the patient's problem: How much and how long will the physician have to prescribe the controlled substances or other prescription medication? Certainly the use of scheduled substances lends itself to a high degree of complexity and abuse.

[5] See also the Board's position paper on the use of chronic opioids for chronic pain, March 15, 1996. The Medical Board has encountered such cases as this. Sometimes the physician is required to completely surrender his or her DEA or Board, or both, for a probationary period.

[6] Montana Code Annotated Sections 37-3-101 and 37-3-202

[7] However, see footnote 1 above.

3. Q. "Is it somehow better for a physician's family member to have to go to another physician, and pay co-payments to get the same drugs?"

   A. The Board of Medical Examiners position is, "In general, 'yes' for the reasons set forth above.

4. Q. What if a physician asked a colleague to prescribe the same drugs or order a diagnostic study without seeing the family member and just take the physician's word for the necessity and appropriateness of the prescription or the diagnostic study?"

   A. The Board of Medical Examiners would not find that acceptable.[8] Although there may be circumstances where the treating physician does not actually see the patient (e.g., the Saturday night prescription of amoxicillin for otitis media, by the physician taking call), the Board's position is that, in general, standard of care requires a physician to establish a direct relationship with the patient the physician is treating, and to document the physician's medical findings and decisions in appropriate medical records.

In conclusion, the Board of Medical Examiners would encourage Montana-licensed physicians to consider carefully the legal and medical disadvantages of prescribing or ordering diagnostic studies for self or immediate family members. If after due consideration, the physician elects to issue such prescription or ordering diagnostic studies, the Board would urge the physician to protect both himself or herself, and the family member, with appropriate medical records supporting the prescriptions.

This statement reflects the Board's understanding of the laws and rules on this subject, and does not purport to be a law, rule or regulation in itself.

Adopted: October 21, 1998

Amended: May 19, 2011

[8] See statutory and regulatory definitions of "unprofessional conduct," which includes by numerous kinds of fraud. Mont. Code Ann. Section 37-1-316, and Adm. Rules of Mont., Rule 24.156.625.

MONTANA BOARD OF MEDICAL EXAMINER

ETHICS FOR MEDICAL PROFESSIONALS

The Board of Medical Examiners recognizes the fundamental obligation of medical professionals to have knowledge and an appreciation of the principles of medical ethics. The medical practice act in most, if not all, states requires that physicians behave ethically in order to acquire and maintain a medical license. The Montana Medical Practice Act requires physicians be of good moral character (37-3-305, MCA) in order to obtain and retain a license.

In circumstances in which the moral character of a licensee is questioned, the Board will evaluate each case on its individual merits and Board Members will apply their best judgment of then current Medical Ethics. The Board will give considerable weight to the AMA Code of Medical Ethics, which originated over 100 years ago, continues to evolve with medical practice, and is the most widely accepted standard of ethical practice in the United States.

The Board acknowledges that the AMA Code of Medical Ethics is a key component of the ethical fabric of the medical profession. This code consists of the Principles of Medical Ethics, which are adopted by the AMA's House of Delegates, and the Current Opinions of the Council on Ethical and Judicial Affairs, which interpret the principles. The AMA's Code of Ethics is widely disseminated and has provided the most commonly cited standard for courts, legislatures, administrative agencies, medical boards and other peer review entities. This code is accepted as the profession's code by most medical societies and virtually all state medical societies.

The Board recognizes ethics can play a critical role in protecting the public as medical ethics guides the development and practice of physicians. The Board endorses the position that an increased emphasis be placed on the examination of prospective licensees with respect to their knowledge of medical ethics. Indeed, one of the basic requirements of medical schools is to encourage students to develop and employ scrupulous ethical principles in caring for patients, in relating to patients' families, and to others involved in the care of the patients." The Board supports the actions taken by AMA to facilitate education and examination in ethics by making its Code of Ethics available to every student entering medical school each year as well as to every student sitting for the USMLE. The Board recognizes it can be an indispensable tool for discussing and addressing the central ethical issues faced by physicians today, and examination questions can be drawn from the code's opinions.

AMA Medical Ethics

Principles of Medical Ethics

Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

Principles of medical ethics

I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people.

Adopted by the AMA's House of Delegates June 17, 2001.

Ethics for Medical Professionals Position Paper

Adopted: May 19, 2011

SB 423 Rule Draft (Proposed as DPHHS Rule)

"NEW RULE X(a): Pursuant to Section 3(10) of SB 423, the department shall provide the board of medical examiners with the name of any physician who provides written certification for 25 or more patients within a 12-month period, and the board of medical examiners shall review the physician's ~~certification~~ medical practices relative to medical marijuana certification in order to determine whether those practices meet the standard of care set forth in Section 1(18) of SB 423.

(b) The board may conduct its review by means of contract, formal peer review, or any other means acceptable to the board and the department. Such review may be conducted at any time within the 12-month period following the board's receipt of ~~during which the board receives~~ a physician's name. The board is not limited to reviewing the first 25 cases of certification, but may review ~~any~~ the record of ~~a~~ any patient who is certified once the physician's name is provided to the board.

"NEW RULE Y: Pursuant to Section 10((b) of SB423, the cost of the board's review of a physician's practices in providing written certification shall be paid to the board by the physician under review. The board, in consultation with the department, may set fees commensurate with cost for such review.

24.156.444 RELAPSE REPORTING

(1) The professional assistance program shall define what constitutes "relapse" for each particular participant and determine if and when relapse has occurred.

(a) A participant who has a single episode of relapse and/or early detection of relapse with nominal substance abuse may be reported to the board by the professional assistance program.

(b) A participant who has ~~a second~~ more than one relapse or a severe relapse during the period the participant is under contract with the professional assistance program must be reported by the professional assistance program to the board screening panel for review.

(2) Any of the following may be required by the board, upon the recommendation of the professional assistance program, when a participant suffers relapse:

(a) the participant may be required to withdraw from practice;

(b) the participant may undergo further recommended evaluation and/or treatment as determined by the professional assistance program;

(c) the participant's monitoring agreement required by the professional assistance program must be reassessed and may be modified;

(d) the participant may be required to comply with other recommendations of the professional assistance program; or

(e) the participant may be subject to discipline as imposed by a board final order.

(3) The board shall take disciplinary action against the license of a participant who has a third relapse during the period the participant is under contract with the professional assistance program.

SB 27 Add Acupuncturist to Board of Medical Examiners
Rule amendment

Acupuncture Licensing Fees

24.156.1402 FEES
(1) An applicant for licensure shall remit a license fee of ~~$65~~ ___ with his or her application.
(2) The renewal fee to practice acupuncture will be: ~~$100~~ _____
(3) Additional standardized fees are specified in ARM 24.101.403.

Facts to consider

- 144 acupuncturists licensed as of May 2011
- No new licensees in 2011
- 6 new licensees in 2010 and 4 in each year of 2008 and 2009
- Last fee increase was in 1999

New board member costs

- Cost projected at $3,835/year for new board member.
- Cost to licensees: $26.60/year

Database costs

- Board will absorb one-time cost for new database at $222,565
- Additional ongoing cost projected at $44,513 for board per year for new database maintenance contract
- Spread cost equally to licensees (project licensee number at 10,500, includes 10 % increase) is $4.23/cost per year per licensee.

Other costs
Board will likely see increase in fixed costs, contract costs, and personnel costs

Options

1) Increase renewal fee to cover board member cost: $53.20. Fee would increase from $100 to $155 for two year renewal. Keep application fee at $65. Plan for second fee increase after FY 2012 budget is set.

2) Increase renewal fess to cover board member and database maintenance cost: $61.66. Fee would increase from $100 to $160.00. Raise fee for applicant to $100.

3) Hold off on increasing fees until FY 2112 budget is set

GUIDANCE FOR MONTANA OUT-OF-HOSPITAL PROVIDERS

Out-of-hospital medicine is the medical care provided in the prehospital environment and during interfacility patient transfers.

The Montana Board of Medical Examiners believes that the provision of out-of-hospital medical care should be provided by licensed health care providers with the skills and knowledge required to provide care in the out-of-hospital environment.

The skills and knowledge objectives for the prehospital provider are defined by the Montana Prehospital Protocols and the current National Emergency Medical Services Education Standards.

The medical director is responsible for the overall medical care provided by out-of-hospital providers as is true of physicians in other medical environments such as the emergency department, surgical suite, nursing home or intensive care unit. However, the determination of the health care provider's individual skills and knowledge is the responsibility of the organization or facility that utilizes that individual. In the manner that a hospital will determine the adequacy of skills and knowledge of a health care professional to function in the emergency department, the prehospital organization will determine adequacy of skills and knowledge of a health care professional to function in the prehospital environment.

Adopted: May 19, 2011