



**MEDICAL EXAMINING BOARD**  
**Room 121A, 1400 East Washington Avenue, Madison**  
**Contact: Tom Ryan (608) 266-2112**  
**March 18, 2015**

*The following agenda describes the issues that the Board plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a record of the actions of the Board.*

**AGENDA**

**8:00 A.M.**

**OPEN SESSION – CALL TO ORDER – ROLL CALL**

- A) Adoption of Agenda (1-5)**
- B) Approval of Minutes of February 18, 2015 (6-11)**
- C) Administrative Updates**
  - 1) Department Staff Updates
  - 2) Appointments/Reappointments/Confirmations
  - 3) Liaison Appointments
  - 4) Wis. Stat. s 15.085 (3)(b) – Affiliated Credentialing Boards’ Biannual Meeting with the Medical Examining Board to Consider Matters of Joint Interest
  - 5) Other Informational Items
- D) Motion to Vacate: In the Matter of the Disciplinary Proceedings Against Nanette J. Liegeois, M.D., Respondent (DHA Case SPS-14-0101)(DLSC Case 14 MED 581) (12-30)**
  - 1) **8:00 A.M. – APPEARANCES** – Christianna L. Finnern, Attorney of Respondent, and Joost Kap, Division of Legal Services and Compliance Attorney
- E) Board Newsletter – Discussion**
- F) Federation of State Medical Boards (FSMB) Matters**
  - 1) Interstate Medical Licensure Compact – Report by Dr. Swan **(31-90)**
    - a) **TELEPHONE APPEARANCE** – Eric Fish, FSMB Representative
  - 2) Annual Meeting Resolutions **(91-98)**
- G) National Governors Association’s Policy Academy on Reducing Prescription Drug Abuse – Report from Dr. Timothy Westlake (99)**
- H) Maintenance of Licensure – Discussion**
- I) North Carolina State Board of Dental Examiners v. Federal Trade Commission – Board Discussion (100-136)**

- J) **Legislative/Administrative Rule Matters**
  - 1) Update on Pending and Possible Rule Projects
- K) Speaking Engagement(s), Travel, or Public Relation Request(s)
- L) Screening Panel Report
- M) Informational Items
- N) Items Added After Preparation of Agenda
  - 1) Introductions, Announcements and Recognition
  - 2) Administrative Updates
  - 3) Education and Examination Matters
  - 4) Credentialing Matters
  - 5) Practice Matters
  - 6) Legislation/Administrative Rule Matters
  - 7) Liaison Report(s)
  - 8) Informational Item(s)
  - 9) Disciplinary Matters
  - 10) Presentations of Petition(s) for Summary Suspension
  - 11) Presentation of Proposed Stipulation(s), Final Decision(s) and Order(s)
  - 12) Presentation of Proposed Decisions
  - 13) Presentation of Interim Order(s)
  - 14) Petitions for Re-Hearing
  - 15) Petitions for Assessments
  - 16) Petitions to Vacate Order(s)
  - 17) Petitions for Designation of Hearing Examiner
  - 18) Requests for Disciplinary Proceeding Presentations
  - 19) Motions
  - 20) Petitions
  - 21) Appearances from Requests Received or Renewed
  - 22) Speaking Engagement(s), Travel, or Public Relation Request(s), and Reports
- O) Public Comments

**CONVENE TO CLOSED SESSION to deliberate on cases following hearing (§ 19.85 (1) (a), Stats.); to consider licensure or certification of individuals (§ 19.85 (1) (b), Stats.); to consider closing disciplinary investigations with administrative warnings (§ 19.85 (1) (b), Stats. and § 448.02 (8), Stats.); to consider individual histories or disciplinary data (§ 19.85 (1) (f), Stats.); and to confer with legal counsel (§ 19.85 (1) (g), Stats.).**

- P) **Monitoring Matters (137-138)**
  - 1) Amy Grelle – Requesting Modification of Order **(139-150)**
  - 2) John Hale – Requesting Full Reinstatement of License **(151-167)**
  - 3) Stephen Haughey – Requesting Modification of Order **(168-187)**
- Q) **Petition for Examination in Case Number 13 MED 469, Shaker H. Itani, M.D. (188-243)**
- R) **Proposed Final Decision and Order: In the Matter of the Disciplinary Proceedings Against Angelina M. Montemurro, M.D., Respondent (DHA Case SPS-14-0103)(DLSC Case 12 MED 288) (244-257)**

- S) **Proposed Final Decision and Order: In the Matter of the Disciplinary Proceedings Against Linda R. Rogow, M.D., Respondent (DHA Case SPS-14-0100)(DLSC Case 14 MED 033) (258-267)**
- T) **Proposed Final Decision and Order: In the Matter of the Disciplinary Proceedings Against Zulfiqar Ali, M.D., Respondent (DHA Case SPS-14-0093)(DLSC Case 14 MED 298) (268-276)**
- U) **Proposed Final Decision and Order: In the Matter of the Disciplinary Proceedings Against Nanette J. Liegeois, M.D., Respondent (DHA Case SPS-14-0101) (DLSC Case 14 MED 581) (277-288)**
- V) **Deliberation on Proposed Stipulations, Final Decisions and Orders by the Division of Legal Services and Compliance (DLSC)**
  - 1) Arlyn A. Koeller, M.D. – 13 MED 117 **(289-295)**
  - 2) Deborah A. Dryer, M.D. – 13 MED 117 **(296-302)**
  - 3) Johnspencer C. Archinihu, M.D. – 13 MED 231 **(303-310)**
  - 4) Westcot G. Krieger, M.D. – 13 MED 329 **(311-324)**
  - 5) Stephen F. Welch, M.D. – 14 MED 014 **(325-330)**
  - 6) Isidoro V. Zambrano, M.D. – 14 MED 165 **(331-336)**
  - 7) Jocelyn Eiche, M.D. – 14 MED 230 **(337-343)**
  - 8) Alicia A. Frankwitz, D.O. – 14 MED 305 **(344-350)**
- W) **Deliberation on Complaints for Determination of Probable Cause**
  - 1) Westscot G. Krieger, M.D. – 13 MED 329 **(351-355)**
- X) **Deliberation on Administrative Warnings**
  - 1) 13 MED 529 – P.N.B. **(356-357)**
  - 2) 14 MED 116 – S.B.S. **(358-359)**
  - 3) 14 MED 135 – V.M.K. **(360-362)**
  - 4) 14 MED 138 – C.T. **(363-364)**
  - 5) 14 MED 166 – S.S. **(365-366)**
- Y) **Petitions for Extension of Time**
  - 1) 14 MED 070 – Unknown **(367-371)**
  - 2) 14 MED 104 – R.J.D. **(372-376)**
- Z) **Case Closing(s)**
  - 1) 13 MED 290 **(377-380)**
  - 2) 13 MED 426 **(381-384)**
  - 3) 14 MED 044 **(385-386)**
  - 4) 14 MED 157 **(387-389)**
  - 5) 14 MED 175 **(390-393)**
  - 6) 14 MED 328 **(394-396)**
  - 7) 14 MED 391 **(397)**
  - 8) 14 MED 397 **(398)**
  - 9) 14 MED 398 **(399)**
  - 10) 14 MED 399 **(400)**
  - 11) 14 MED 400 **(401)**

- 12) 14 MED 401 **(402)**
- 13) 14 MED 402 **(403)**
- 14) 14 MED 403 **(404)**
- 15) 14 MED 406 **(405)**
- 16) 14 MED 408 **(406)**
- 17) 14 MED 409 **(407)**
- 18) 14 MED 411 **(408)**
- 19) 14 MED 415 **(409)**
- 20) 14 MED 416 **(410)**
- 21) 14 MED 420 **(411)**
- 22) 14 MED 421 **(412)**
- 23) 14 MED 425 **(413)**
- 24) 14 MED 427 **(414)**
- 25) 14 MED 436 **(415)**
- 26) 14 MED 438 **(416)**
- 27) 14 MED 439 **(417)**
- 28) 14 MED 441 **(418-419)**
- 29) 14 MED 444 **(420)**
- 30) 14 MED 447 **(421)**
- 31) 14 MED 457 **(422)**
- 32) 14 MED 461 **(423)**
- 33) 14 MED 464 **(424)**
- 34) 14 MED 470 **(425)**
- 35) 14 MED 472 **(426)**
- 36) 14 MED 474 **(427)**
- 37) 14 MED 483 **(428)**
- 38) 14 MED 485 **(429)**
- 39) 14 MED 488 **(430)**
- 40) 14 MED 490 **(431)**
- 41) 14 MED 491 **(432)**
- 42) 14 MED 492 **(433)**
- 43) 14 MED 494 **(434)**
- 44) 14 MED 495 **(435)**
- 45) 14 MED 499 **(436)**
- 46) 14 MED 500 **(437)**
- 47) 14 MED 502 **(438)**
- 48) 14 MED 540 **(439-450)**
- 49) 14 MED 545 **(451-458)**
- 50) 14 MED 547 **(459-464)**
- 51) 14 MED 550 **(465-469)**
- 52) 14 MED 560 **(470-477)**

**AA) Case Status Report (478-487)**

**BB) Deliberation of Items Added After Preparation of the Agenda**

- 1) Education and Examination Matters
- 2) Credentialing Matters

- 3) Disciplinary Matters
- 4) Monitoring Matters
- 5) Professional Assistance Procedure (PAP) Matters
- 6) Petition(s) for Summary Suspensions
- 7) Proposed Stipulations, Final Decisions and Orders
- 8) Administrative Warnings
- 9) Proposed Decisions
- 10) Matters Relating to Costs
- 11) Complaints
- 12) Case Closings
- 13) Case Status Report
- 14) Petition(s) for Extension of Time
- 15) Proposed Interim Orders
- 16) Petitions for Assessments and Evaluations
- 17) Petitions to Vacate Orders
- 18) Remedial Education Cases
- 19) Motions
- 20) Petitions for Re-Hearing
- 21) Appearances from Requests Received or Renewed

CC) Consulting with Legal Counsel

**RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION**

DD) Open Session Items Noticed Above not Completed in the Initial Open Session

EE) Vote on Items Considered or Deliberated Upon in Closed Session, if Voting is Appropriate

FF) Delegation of Ratification of Examination Results and Ratification of Licenses and Certificates

**ADJOURNMENT**

**ORAL EXAMINATION OF CANDIDATES FOR LICENSURE**

**ROOM 124D/E**

**11:15 A.M., OR IMMEDIATELY FOLLOWING FULL BOARD MEETING**

**CLOSED SESSION** – Reviewing applications and conducting oral examinations of two (2) candidates for licensure – Drs. Misra, Phillips, Swan, Westlake.

**MEDICAL EXAMINING BOARD  
MEETING MINUTES  
February 18, 2015**

**PRESENT:** Mary Jo Capodice, D.O; Rodney Erickson, M.D.; Suresh Misra, M.D.; Carolyn Ogland Vukich, M.D.; Michael Phillips, M.D.; Kenneth Simons, M.D.; Timothy Swan, M.D.; Sridhar Vasudevan, M.D.; Timothy Westlake, M.D. (*arrived at 8:03 a.m.*); Russell Yale, M.D.; Robert Zondag

**EXCUSED:** James Barr, Greg Collins

**STAFF:** Tom Ryan, Executive Director; Taylor Thompson, Bureau Assistant; and other Department staff

**CALL TO ORDER**

Kenneth Simons, Chair, called the meeting to order at 8:00 a.m. A quorum of ten (10) members was confirmed.

**ADOPTION OF AGENDA**

**Amendments:**

- Remove Item D) Intake Complaint Process and appearance from Kelley Sankbeil
- Correct Item J) to read “Level 2”
- Remove Item T)2) Proposed Stipulation, Final Decision and Order of Karen Butler, M.D. – 13 MED 308

**MOTION:** Michael Phillips moved, seconded by Suresh Misra, to adopt the agenda as amended. Motion carried unanimously.

**APPROVAL OF MINUTES**

**Corrections:**

- Case Closing 14 MED 444 should be corrected to read as “12 MED 444”
- Correct motion in the matter of Nitinrai Pandya, MD to read “is not substantially” in the reason for denial.

**MOTION:** Sridhar Vasudevan moved, seconded by Carolyn Ogland Vukich, to approve the minutes of January 21, 2015 as corrected. Motion carried unanimously.

**ADMINISTRATIVE UPDATES**

**DELEGATED AUTHORITY MOTIONS**

**MOTION:** Suresh Misra moved, seconded by Mary Jo Capodice, to rescind the delegated authority motion from the January meeting and adopt the updated Roles and Authorities Delegated to the Monitoring Liaison and Department Monitor document as presented in today’s agenda packet. Motion carried unanimously.

**CONSIDERATION OF JENNIFER L. JARRETT, MPAS, PA-C, FOR APPOINTMENT TO THE COUNCIL ON PHYSICIAN ASSISTANTS**

**MOTION:** Sridhar Vasudevan moved, seconded by Michael Phillips, to appoint Jennifer L. Jarrett to the Council on Physician Assistants as a physician assistant member, as of 7/1/2015 for a term to expire on 7/1/2019. Motion carried unanimously.

**NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS REQUEST FOR NOMINATIONS TO STANDARD SETTING PANEL FOR THE HUMANISTIC DOMAIN OF COMLEX-USA LEVEL 2 – PERFORMANCE EVALUATION – BOARD CONSIDERATION**

**MOTION:** Sridhar Vasudevan moved, seconded by Russell Yale, to nominate Mary Jo Capodice to serve as a member of the National Board of Osteopathic Medical Examiners standard setting panel for the Humanistic Domain of COMLEX-USA Level 2 – Performance Evaluation. Motion carried unanimously.

**LEGISLATIVE/ADMINISTRATIVE RULE MATTERS**

**REVIEW OF MED 1.04 RELATING TO ENTRANCE TO EXAM**

**MOTION:** Sridhar Vasudevan moved, seconded by Robert Zondag, to approve the draft as amended for filing Med 1, 3, 5 relating to Physician Licensure for posting of EIA Comments and submission to the Clearinghouse. Motion carried unanimously.

**CLOSED SESSION**

**MOTION:** Sridhar Vasudevan moved, seconded by Carolyn Ogland Vukich, to convene to Closed Session to deliberate on cases following hearing (§ 19.85 (1) (a), Stats.); to consider licensure or certification of individuals (§ 19.85 (1) (b), Stats.); to consider closing disciplinary investigations with administrative warnings (§ 19.85 (1) (b), Stats. and § 448.02 (8), Stats.); to consider individual histories or disciplinary data (§ 19.85 (1) (f), Stats.); and to confer with legal counsel (§ 19.85 (1) (g), Stats.). The Chair read the language of the motion aloud for the record. The vote of each member was ascertained by voice vote. Roll Call Vote: Mary Jo Capodice – yes; Rodney Erickson – yes; Suresh Misra – yes; Carolyn Ogland Vukich – Yes; Michael Phillips – Yes; Kenneth Simons – yes; Timothy Swan – yes; Sridhar Vasudevan – yes; Timothy Westlake – yes; Russell Yale – yes; and Robert Zondag – yes. Motion carried unanimously.

The Board convened into Closed Session at 8:57 a.m.

**RECONVENE TO OPEN SESSION**

**MOTION:** Mary Jo Capodice moved, seconded by Suresh Misra, to reconvene in Open Session at 10:42 a.m. Motion carried unanimously.

**VOTE ON ITEMS CONSIDERED OR DELIBERATED UPON IN CLOSED SESSION,  
IF VOTING IS APPROPRIATE**

**MOTION:** Suresh Misra moved, seconded by Robert Zondag, to affirm all motions made and votes taken in Closed Session. Motion carried unanimously.

**SEEKING EQUIVALENCY FOR THE 12 MONTHS OF ACGME APPROVED POST-GRADUATE TRAINING BASED ON EDUCATION AND TRAINING**

**AZAR SHEIKHOESLAMI, M.D.**

**MOTION:** Timothy Westlake moved, seconded by Suresh Misra, to find that the training and education of Azar Sheikholeslami, M.D. is not substantially equivalent to the requirements set forth in Wis. Stat. § 448.05(2). Motion carried unanimously.

**MONITORING MATTERS**

**FARID A. AHMAD – REQUESTING RETURN OF FULL UNRESTRICTED LICENSE**

**MOTION:** Timothy Swan moved, seconded by Carolyn Ogland Vukich, to deny Farid Ahmad's request for full unrestricted license. **Reason for denial:** the Respondent did not comply with the Order, page 2, paragraph 2. The Respondent did not complete the CPEP post evaluation, as required per the Order. Motion carried unanimously.

**CAROL HAUGHEY, P.A. – REQUESTING MODIFICATIONS OF REQUIREMENTS**

**MOTION:** Timothy Swan moved, seconded by Carolyn Ogland Vukich, to grant the request of Carol Haughey for a reduction of drug screens to 36 with an annual hair test. Motion carried unanimously.

**MOTION:** Timothy Swan moved, seconded by Carolyn Ogland Vukich, to deny the request to work in an environment with access to controlled substances. **Reason for denial:** Further compliance under the Order is required before additional modifications will be considered. Motion carried unanimously.

**ELEAZAR KADILE – REQUESTING MODIFICATIONS OF REQUIREMENTS**

**MOTION:** Timothy Swan moved, seconded by Suresh Misra, to deny the request of Eleazar Kadile for approval to engage in research on human subjects. **Reason for denial:** The Respondent is not in compliance with the current Order. Motion carried unanimously.

**HEATH MEYER – REQUESTING MODIFICATIONS OF REQUIREMENTS**

**MOTION:** Timothy Westlake moved, seconded by Russell Yale, to grant the request of Heath Meyer for a reduction in drug screens to 28 times per year and a hair test, and therapy visits on an as needed basis. Motion carried unanimously.

**JONATHAN THOMAS – REQUESTING REDUCTION IN DRUG AND ALCOHOL SCREENS**

**MOTION:** Robert Zondag moved, seconded by Rodney Erickson, to grant the request of Johnathan Thomas for a reduction in drug and alcohol screens from 25 times per year to 14 times per year, and to be able to travel internationally and have the screens suspended during that time. These modifications are approved while the Respondent is not working as a Physician. However, when the Respondent returns to the workforce as a Physician, the Board will revisit these modifications.  
Motion carried.

**DELIBERATION ON PROPOSED STIPULATIONS, FINAL DECISIONS AND ORDERS BY THE DIVISION OF LEGAL SERVICES AND COMPLIANCE (DLSC)**

**KAREN BUTLER, M.D. – 13 MED 161**

**MOTION:** Sridhar Vasudevan moved, seconded by Carolyn Ogland Vukich, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Karen Butler, M.D., DLSC case number 13 MED 161.  
Motion carried unanimously.

**JAMES R. LLOYD, M.D. – 13 MED 321**

*Dr. Vasudevan recused himself for the deliberation and voting in the matter of James R. Lloyd, M.D. – 13 MED 321*

**MOTION:** Timothy Swan moved, seconded by Rodney Erickson, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against James R. Lloyd, M.D., DLSC case number 13 MED 321. Motion carried unanimously.

**LOUIS SENO, JR., M.D. – 13 MED 433**

**MOTION:** Carolyn Ogland Vukich moved, seconded by Michael Phillips, to reject the Stipulation, Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Louis Seno, Jr., M.D., DLSC case number 13 MED 433. Motion carried unanimously.

**DAVID S. BUDDE, M.D. – 14 MED 519**

**MOTION:** Michael Phillips moved, seconded by Suresh Misra, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against David S. Budde, M.D., DLSC case number 14 MED 519. Motion carried unanimously.

**JOHN D. WOLSKI, D.O. – 14 MED 579**

**MOTION:** Sridhar Vasudevan moved, seconded by Russell Yale, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against John D. Wolski, D.O., DLSC case number 14 MED 579. Motion carried unanimously.

**DELIBERATION ON COMPLAINTS FOR DETERMINATION OF PROBABLE CAUSE**

**GLENN STOW, M.D. – 14 MED 379**

*Dr. Vasudevan recused himself for the deliberation and voting in the matter Glenn Stow, M.D. – 14 MED 379*

**MOTION:** Timothy Westlake moved, seconded by Suresh Misra, to find probable cause to believe that Glenn Stow, M.D., DLSC case number 14 MED 379, is guilty of unprofessional conduct, and therefore to issue the Complaint and hold a hearing on such conduct pursuant to Wis. Stat. § 448.02(3)(b). Motion carried.

**PRESENTATION AND DELIBERATION ON ADMINISTRATIVE WARNING(S)**

**14 MED 319 – A.J.**

**MOTION:** Mary Jo Capodice moved, seconded by Timothy Westlake, to issue an Administrative Warning in the matter of DLSC case number 14 MED 319 (A.J.). Motion carried unanimously.

**CASE CLOSING(S)**

**12 MED 042 – A.Y. AND H.D.**

*Drs. Vasudevan and Yale recused themselves for the deliberation and voting in the matter of 12 MED 042 – A.Y. and H.D.*

**MOTION:** Timothy Swan moved, seconded by Rodney Erickson, to close DLSC case number 12 MED 042, against A.Y. and H.D., for insufficient evidence (IE). Motion carried.

**MOTION:** Michael Phillips moved, seconded by Timothy Swan, to close the following cases according to the recommendations by the Division of Legal Services and Compliance:

1. 13 MED 181 (S.B.A.) for prosecutorial discretion (P2)
2. 13 MED 308 (T.C.) for no violation (NV)
3. 13 MED 509 (J.C.L.) for no violation (NV)
4. 14 MED 342 (A.J.C.) for no violation (NV)
5. 14 MED 512 (M.A.B.) for prosecutorial discretion (P2)
6. 14 MED 541 (C.L.K.) for no violation (NV)
7. 14 MED 548 (S.G.S.) for insufficient evidence (IE)
8. 14 MED 551 (S.H.V.) for no violation (NV)

Motion carried.

#### **DELEGATION OF RATIFICATION OF EXAMINATION RESULTS AND RATIFICATION OF LICENSES AND CERTIFICATES**

**MOTION:** Mary Jo Capodice moved, seconded by Robert Zondag, to delegate ratification of examination results to DSPS staff and to ratify all licenses and certificates as issued. Motion carried unanimously.

#### **ADJOURNMENT**

**MOTION:** Michael Phillips moved, seconded by Timothy Westlake, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 10:43 a.m.

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

|  |   |  |  |  |                      |             |                   |  |                   |                          |  |      |   |  |      |
|--|---|--|--|--|----------------------|-------------|-------------------|--|-------------------|--------------------------|--|------|---|--|------|
| <b>1) Name and Title of Person Submitting the Request:</b><br><br>Shawn Leatherwood, Legal Associate   |   | <b>2) Date When Request Submitted:</b><br><br>February 25, 2015<br><br><small>Items will be considered late if submitted after 12:00 p.m. and less than:<br/>                 ▪ 8 work days before the meeting</small> |  |  |                      |             |                   |  |                   |                          |  |      |   |  |      |
| <b>3) Name of Board, Committee, Council, Sections:</b><br><br>Medical Examining Board  |   |  |  |  |                      |             |                   |  |                   |                          |  |      |   |  |      |
| <b>4) Meeting Date:</b><br><br>March 18, 2015  | <b>5) Attachments:</b><br><input checked="" type="checkbox"/> Yes<br><input type="checkbox"/> No  | <b>6) How should the item be titled on the agenda page?</b><br>In the Matter of the Disciplinary Proceedings Against<br>Nanette J. Liegeois, M.D. Respondent (DHA Case<br>No.SPS-14-0101 DLSC Case No. 14 MED 581      |  |  |                      |             |                   |  |                   |                          |  |      |   |  |      |
| <b>7) Place Item in:</b><br><input checked="" type="checkbox"/> Open Session<br><input type="checkbox"/> Closed Session<br><input type="checkbox"/> Both   | <b>8) Is an appearance before the Board being scheduled? If yes, who is appearing?</b><br><input checked="" type="checkbox"/> Yes by Christianna L. Finnern and<br>Joost Kap at 8:00 AM<br><small>(name)</small><br><input type="checkbox"/> No | <b>9) Name of Case Advisor(s), if required:</b>  |  |  |                      |             |                   |  |                   |                          |  |      |   |  |      |
| <b>10) Describe the issue and action that should be addressed:</b><br><br>The Board will consider the Respondent's request to Vacate the Proposed Decision and Order and allow the respondent to answer the complaint.   |   |  |  |  |                      |             |                   |  |                   |                          |  |      |   |  |      |
| <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;"><b>11) Signature of person making this request</b></td> <td style="width: 20%; text-align: center;"><b>Authorization</b></td> <td style="width: 20%; text-align: center;"><b>Date</b></td> </tr> <tr> <td>Shawn Leatherwood</td> <td></td> <td style="text-align: center;">February 25, 2015</td> </tr> <tr> <td>Supervisor (if required)</td> <td></td> <td style="text-align: center;">Date</td> </tr> <tr> <td colspan="2">Bureau Director signature (indicates approval to add post agenda deadline item to agenda)</td> <td style="text-align: center;">Date</td> </tr> </table> |   |  |  | <b>11) Signature of person making this request</b> | <b>Authorization</b> | <b>Date</b> | Shawn Leatherwood |  | February 25, 2015 | Supervisor (if required) |  | Date | Bureau Director signature (indicates approval to add post agenda deadline item to agenda) |  | Date |
| <b>11) Signature of person making this request</b>   | <b>Authorization</b>  | <b>Date</b>  |  |  |                      |             |                   |  |                   |                          |  |      |   |  |      |
| Shawn Leatherwood  |   | February 25, 2015  |  |  |                      |             |                   |  |                   |                          |  |      |   |  |      |
| Supervisor (if required)   |   | Date   |  |  |                      |             |                   |  |                   |                          |  |      |   |  |      |
| Bureau Director signature (indicates approval to add post agenda deadline item to agenda)  |   | Date   |  |  |                      |             |                   |  |                   |                          |  |      |   |  |      |
| <b>Directions for including supporting documents:</b><br>1. This form should be attached to any documents submitted to the agenda.<br>2. Post Agenda Deadline items must be authorized by a Supervisor and the Board Services Bureau Director.<br>3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.   |   |  |  |  |                      |             |                   |  |                   |                          |  |      |   |  |      |

March 11, 2015

Christianna L. Finnern  
Direct Dial: (612) 604-6435  
Direct Fax: (612) 604-6935  
cfinnern@winthrop.com

**VIA FEDERAL EXPRESS**

Mr. Tom Ryan, Executive Director  
Wisconsin Medical Examining Board  
Department of Safety and Professional Services  
1400 East Washington Avenue, Room 116  
Madison, WI 53708

Re: Dr. Nanette J. Liegeois, M.D., Ph.D.  
DHS Case No. SPS-14-0101  
DLSC Case No. 14 MED 581

Dear Mr. Ryan:

This firm represents Dr. Nanette Liegeois, M.D., Ph.D. (“Dr. Liegeois”) in connection with the above-referenced matter. We respectfully request that the Medical Examining Board (the “Board”) vacate the default entered against Dr. Liegeois and allow her to respond to the Complaint issued against her on December 11, 2014 by the Division of Legal Services and Compliance. In the alternative, we respectfully request that the Board allow Dr. Liegeois to respond to the proposed discipline set forth in the Proposed Decision and Order issued on February 3, 2015.

**I. FACTUAL AND PROCEDURAL BACKGROUND.**

Dr. Liegeois was first licensed in the State of Wisconsin to practice medicine and surgery, having license number 60872-20, on June 3, 2013. She is a dermatologist by training. She earned a Master’s degree in immunology in 1995 and a Ph.D. in immunology in 1998 from Albert Einstein College of Medicine in New York, New York. From 1998 to 1999, Dr. Liegeois interned at Harvard Medical School and Beth Israel Deaconess Medical Center. She was a resident at Harvard Medical School and seven other hospitals in the Boston area from 1999 to 2001 and was selected Chief Resident at Harvard Medical School. In 2003, Dr. Liegeois was selected for a yearlong fellowship in Mohs Surgery and Cutaneous Oncology by Lahey Hospital & Medical Center, Department of Dermatology, which is affiliated with Harvard Medical School. She is an author of 38 scholarly articles published in medical journals such as the Journal of the American Academy of Dermatology, Modern Pathology, Dermatologic Surgery and the International Journal of Oncology.

She was employed by Johns Hopkins at Johns Hopkins School of Medicine as an Assistant Professor in the Department of Dermatology from November 3, 2003 until October 1, 2009 and as an Adjunct Assistant Professor in the Oncology Department from February 2010 to October 31, 2012. Throughout her employment, Dr. Liegeois excelled in the duties of her position and there were no issues regarding her performance. Dr. Liegeois established and directed the Cutaneous Surgery and Oncology unit within the Department of Dermatology. She was also appointed Director of Surgery and was responsible for supervising a Mohs histotechnician, an administrative assistant, a nurse, medical assistants, fellows and residents. She developed numerous novel treatments for chemotherapy and obtained three molecular genetics patents.

On December 10, 2014, Dr. Liegeois was transported to Cambridge Medical Center in Cambridge, Minnesota and admitted on a "72-hour hold" pursuant to Minnesota law authorizing taking custody of and restraining an individual who the peace officer has reason to believe is mentally ill and/or chemically dependent and in imminent danger of injuring herself or others if not immediately restrained. Upon her admission to the hospital, Dr. Liegeois' blood alcohol content was 0.299. She had several psychiatry evaluations during the 72-hour hold and it was recommended that she undergo a chemical dependency evaluation. Dr. Liegeois was discharged on December 13, 2014.

On December 11, 2014, the Division of Legal Services and Compliance (the "Division") issued a Complaint against Dr. Liegeois. On December 19, 2014, the Division issued a Notice of Hearing to Dr. Liegeois. Also on December 19, 2014, the Board issued an Order of Summary Suspension.

On January 20, 2015, Administrative Law Judge Nashold issued a Notice of Default and Order against Dr. Liegeois. Consistent with the Notice, the Division filed a recommended proposed decision and order on January 27, 2015.

On February 3, 2015, Judge Nashold issued a Notice of Filing of Proposed Decision and Order and a Proposed Decision and Order. Among other things, the Notice of Filing of Proposed Decision and Order set forth a deadline of February 23, 2015 for lodging any objections.

On February 24, 2015, Dr. Liegeois filed a Notice of Motion and Motion to Vacate Default. By email dated February 26, 2015, Judge Nashold informed the undersigned that after she issues a proposed order in a case, she views the matter as no longer under her authority. Judge Nashold wrote that Dr. Liegeois' only remedy is with the Board.

Dr. Liegeois wishes to be frank and forthcoming with the Board. Accordingly, Dr. Liegeois admits that she never received the Complaint or subsequent Notice of Hearing, Notice of Filing Proposed Decision and Order, and the Proposed Decision and Order. While Dr. Liegeois has acknowledged that it is her responsibility to maintain current contact information with the applicable regulatory bodies, we responded immediately once we received this information by filing a Motion to Vacate Default Judgment.

## **II. REQUEST TO VACATE DEFAULT OR, ALTERNATIVELY, PERMIT A RESPONSE TO THE PROPOSED DECISION AND ORDER.**

Dr. Liegeois respectfully requests that the Board vacate the default against her and allow her to respond to the allegations in the Complaint. Alternatively, Dr. Liegeois respectfully requests that the Board allow her to respond to the Proposed Decision and Order.

A physician's license represents a constitutionally protected interest and it cannot be revoked, suspended or restricted without due process. The right to earn a living is among the greatest human rights. Where the state confers a license to engage in a profession, this license becomes a valuable personal right that cannot be denied or abridged in any manner except after due notice and a fair and impartial hearing before an unbiased tribunal.

Here, Dr. Liegeois has been unable to respond to the allegations in the Complaint against her. Judge Nashold has indicated that she believes that this case is no longer under her jurisdiction. Section SPS 2.14 of the Wisconsin Administrative Code provides that the Board may, for good cause, relieve Dr. Liegeois from the default and permit her to answer and defend at any time before the Board enters an order or within a reasonable time thereafter. Here, the Board has not yet entered an Order and, therefore, it is appropriate to relieve Dr. Liegeois from the default and allow her to respond to the Complaint against her.

Dr. Liegeois should not be denied her right to procedural due process when she has come forward and requested an opportunity to respond and be heard on the allegations that have been asserted against her. Furthermore, the discipline that has been issued in this case is severe and it would be unjust for Dr. Liegeois to be subject to a five (5) year restriction on her license without having been given a chance to respond. As Prosecuting Attorney Joost Kap indicated in his opposition to our motion to vacate, Dr. Liegeois has admitted that she has significant underlying medical conditions, and while she is willing to undergo treatment, this does not constitute a reason for the Board to deny her due process rights. Therefore, we respectfully request that the Board allow Dr. Liegeois to respond to the Complaint.

In the alternative if the Board refuses to allow Dr. Liegeois to respond to the Complaint we respectfully request that you permit Dr. Liegeois to respond to the proposed discipline. At the outset, Dr. Liegeois wishes to emphasize that she acknowledges and agrees that an evaluation by a mental health care professional is appropriate.

We respectfully request that should the evaluation determine that Dr. Liegeois has any co-occurring chemical dependency issues that she be referred to the Professional Assistance Program (PAP) to address those concerns.

We further respectfully request that since Dr. Liegeois is currently unemployed that she not be responsible for the costs associated with the assessment concerning her competence to practice medicine or the mental health evaluation. In addition, due to the restrictions upon her license it is unlikely that she will obtain employment in her field any time in the immediate future in order to pay for these required evaluations.

Furthermore, we respectfully request that the Board amend the required five (5) year stay period before Dr. Liegeois may petition the Board to terminate the suspension. The five year period is excessive and beyond what is necessary under the circumstances especially considering we are unaware of any actual patient harm related to the allegations against Dr. Liegeois. We request that the Board amend this period to a more reasonable two (2) year period which is an adequate amount of time for Dr. Liegeois to get the required treatment and demonstrate her fitness to practice medicine.

### III. CONCLUSION.

We respectfully request that the Board allow Dr. Liegeois to respond to the allegations asserted against her in the Complaint in order to ensure that she is provided with all of her due process rights. In the alternative, we request that the Board amend the Order to represent fair and appropriate discipline which is commensurate with the allegations asserted against Dr. Liegeois.

Very truly yours,

WINTHROP & WEINSTINE, P.A.  


Christianna L. Finnern

CLF/qcs

cc: Shawn Leatherwood  
Joost Kap

10105144v2

**Before The  
State of Wisconsin  
DIVISION OF HEARINGS AND APPEALS**

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In the Matter of the Disciplinary Proceedings  
Against Nanette J. Liegeois, M.D., Respondent

DHA Case No. SPS-14-0101  
DLSC Case No. 14 MED 581

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**RESPONDENT'S NOTICE OF MOTION AND MOTION  
TO VACATE DEFAULT JUDGMENT**

TO: Attorney Joost Kap, Department of Safety and Professional Services, Division of Legal Services and Compliance, P.O. Box 7190, Madison, WI 53707-7190

PLEASE TAKE NOTICE that Respondent, by and through her undersigned counsel of record, will make the following motion to vacate the default judgment against her before the Honorable Jennifer E. Nashold, Administrative Law Judge, State of Wisconsin, Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705.

**MOTION**

Respondent hereby moves the Court for an Order granting the following relief:

1. Vacating the default judgment entered against Respondent by Proposed Decision and Order dated February 3, 2015; and
2. Permitting Respondent to interpose an Answer to the Division of Legal Services and Compliance's Complaint dated December 11, 2014; and
3. Setting the above-captioned matter on for hearing; and
4. For such other and further relief as this Court may deem just and proper.

Respectfully submitted:

Dated: February 24, 2015

WINTHROP & WEINSTINE, P.A.

By:   
Christianna L. Finnern, #310724

225 South Sixth Street, Suite 3500  
Minneapolis, MN 55402  
Telephone: (612) 604-6400  
Facsimile: (612) 604-6800  
[cfinnern@winthrop.com](mailto:cfinnern@winthrop.com)

*Attorneys for Respondent*

10060594v1

**Before The  
State of Wisconsin  
DIVISION OF HEARINGS AND APPEALS**

---

In the Matter of the Disciplinary Proceedings  
Against Nanette J. Liegeois, M.D., Respondent

DHA Case No. SPS-14-0101  
DLSC Case No. 14 MED 581

---

**RESPONDENT'S MEMORANDUM OF LAW IN SUPPORT OF MOTION  
TO VACATE DEFAULT JUDGMENT**

**I. FACTUAL BACKGROUND**

Respondent was first licensed in the State of Wisconsin to practice medicine and surgery, having license number 60872-20, on June 3, 2013. On December 19, 2014, the Wisconsin Medical Examining Board issued an Order of Summary Suspension as a result of certain complaints made about Respondent's patient care and interactions with her then-employer based on a fitness-for-duty examination that concluded that Respondent was "psychologically not fit for duty as a physician specialist at this time . . . ."

On December 11, 2014, the Division of Legal Services and Compliance (the "Division") issued a Complaint against Respondent. On December 19, 2014, the Division of Legal Services and Compliance issued a Notice of Hearing to Respondent.

On January 20, 2015, Administrative Law Judge Jennifer E. Nashold issued a Notice of Default and Order against Respondent. Consistent with the Notice, the Division filed a recommended proposed decision and order on January 27, 2015.

On February 3, 2015, Judge Nashold issued a Notice of Filing Proposed Decision and Order and a Proposed Decision and Order. Among other things, the Notice of Filing of Proposed Decision and Order set forth a deadline of February 23, 2015 for lodging any objections thereto.

As Judge Nashold writes in the Proposed Decision and Order, the discipline recommended by the Division against Respondent is severe. Judge Nashold also acknowledges that Respondent appears to have significant underlying mental health concerns and does not have any further discipline against her.

Respondent never received the Notice of Hearing or the Complaint. Respondent did not receive the Notice of Default and Order. Respondent did not receive the Notice of Filing Proposed Decision and Order and Proposed Decision and Order. Respondent's address on file with the Wisconsin Department of Safety and Professional Services was not current. Respondent acknowledges that it is her responsibility to maintain current contact information with the applicable regulatory bodies.

Respondent very recently retained the undersigned. Respondent's counsel telephoned the Department of Safety and Professional Services on February 20, 2015. Respondent's counsel was on hold for ten minutes before opting to leave a message on the general voicemail. Respondent received a phone call later that day from an employee who determined that counsel's voicemail had been incorrectly routed to that employee's Division within the Department of Safety and Professional Services. The employee advised Respondent's counsel to call the general number again and ask to speak to Michelle in the Division of Legal Services and Complaint. Counsel did so and left a message for Michelle that day.

On February 24, 2015, counsel received an email from Joost Kap, counsel for the Division. Counsel phoned Attorney Kap and learned that the deadline for objecting to the Proposed Decision and Order had passed by one day.

## II. ARGUMENT

Section SPS 2.14 of the Wisconsin Administrative Code provides for the entry of a default judgment if a respondent fails to answer as required by Section SPS 2.09 or fails to appear at the hearing at the time affixed. The disciplinary authority may, for good cause, relieve the respondent from the effect of such findings and permit the respondent to answer and defend at any time before the disciplinary authority enters an order or within a reasonable time thereafter.

Section HA 1.07(3) of the Wisconsin Administrative Code provides, among other things, that if the respondent fails to appear, the administrative law judge may issue an order or take the allegations in an appeal as true, unless good cause is shown for the failure to appear.

Here, good cause exists to vacate the default judgment and allow Respondent to answer the Complaint. No order has yet been issued. Furthermore, even if an Order had been entered, Respondent is afforded a "reasonable time" after such entry to obtain relief from a default judgment. Respondent's counsel acted immediately when advised of the timing at issue. Therefore, Respondent should be allowed relief from the default based upon the plain language of Section SPS 2.14.

The allegations against Respondent are very severe and the proposed disciplinary action is also very severe. As acknowledged in both the Order of Summary Suspension and the Proposed Decision and Order, Respondent appears to have significant underlying mental health issues. Respondent has never been the subject of any previous discipline in any jurisdiction in which she has been licensed to practice. Respondent is unaware of any actual patient harm related to the allegations against her. Respondent's employment was terminated as a result of the

circumstances giving rise to the Order of Summary Suspension. Respondent is not currently working.

Respondent very recently retained counsel who promptly attempted to contact the Division to discuss Respondent's case. Counsel did not receive a response from the Division until one day after the deadline to object to the Proposed Decision and Order had passed.

Respondent is committed to working with the Board and the Division to satisfactorily address the issues of concern. Respondent is ready and willing to cooperate with the Board fully.

Respondent respectfully requests, however, that she be afforded due process and permitted to respond to the allegations against her in the Complaint and to provide objections and argument, if appropriate, in response to the Proposed Decision and Order.

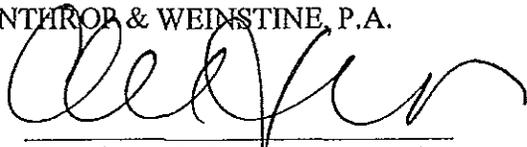
### III. CONCLUSION

For the foregoing reasons Respondent respectfully requests that the default judgment be vacated pursuant to SPS 2.14 of the Wisconsin Administrative Code and Section HA 1.07(3) of the Wisconsin Administrative Code.

Respectfully submitted:

Dated: February 24, 2015

WINTHROP & WEINSTINE, P.A.

By: 

Christianna L. Finnern, #310724

225 South Sixth Street, Suite 3500  
Minneapolis, MN 55402  
Telephone: (612) 604-6400  
Facsimile: (612) 604-6800  
[cfinnern@winthrop.com](mailto:cfinnern@winthrop.com)

*Attorneys for Respondent*

STATE OF WISCONSIN  
BEFORE THE MEDICAL EXAMINING BOARD

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|                                  |   |                          |
|----------------------------------|---|--------------------------|
| IN THE MATTER OF                 | : |                          |
| DISCIPLINARY PROCEEDINGS AGAINST | : |                          |
|                                  | : | DHA Case No. SPS-14-0101 |
| NANETTE J. LIEGEOIS, M.D.,       | : | DLSC Case No. 14 MED 581 |
| RESPONDENT.                      | : |                          |

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BRIEF OPPOSING RESPONDENT’S MOTION TO VACATE DEFAULT JUDGMENT

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The Department of Safety and Professional Services, Division of Legal Services and Compliance (Division) opposes Respondent’s motion to vacate default judgment. The motion was not timely filed and thus should not be considered. Regardless, it does not establish the requisite good cause because default resulted from Respondent’s failure to comply with the law, and her failure to timely acknowledge these proceedings. Finally, to vacate default would delay the evaluation and care that Respondent clearly needs, and impose great time and expense on all involved while needlessly prolonging these proceedings.

**ARGUMENT**

Respondent admits the reason for default is her own failure to maintain current contact information as required by Wis. Stats. § 440.11(2). (Respondent’s Motion Brief, pg. 2) As set out in Judge Nashold’s Proposed Decision and Order, the Division complied with all applicable rules on filing and service. In fact, the Division went beyond what the law requires. In addition to serving Respondent by regular and certified mail (only regular is required), the Order for Summary Suspension and the Notice of Hearing and Complaint were also emailed to Respondent at a Gmail address she provided to the Department. (Affidavit of Beth Cramton, ¶¶ 3 and 4,

Exhibits A and B) There was no error message or other response indicating that Respondent's email address was invalid or otherwise not receiving the emails. *Id.* at ¶ 5

Respondent has now retained Attorney Christianna Finnern.<sup>1</sup> This obviously informs that Respondent was aware of these proceedings. The how and when Respondent became aware is not explained, but the Division infers from the motion that it was since the Board summarily suspended her in mid-December. Respondent claims she did not receive the Notice of Hearing and Complaint nor the Proposed Decision and Order.<sup>2</sup> (Brief, pg. 2) However, Respondent does **not** deny receiving the Order for Summary Suspension, which, as noted above, was served on December 18 via regular and certified mail, and was successfully sent to Respondent's email. On December 19, the Notice of Hearing and Complaint were served in the same way.

Respondent's motion admits that she "appears to have significant underlying mental health issues." (Brief, pg. 3) This is presumably offered to explain Respondent's failure to update her address and/or her failure to appear for two months after these proceedings commenced. The Division agrees that Respondent appears to have significant mental health issues. That is why it pursued summary suspension and proposed the discipline now before the Board, and why the default judgment should stand and the Proposed Decision and Order entered.

The default is Respondent's own creation—by her failure to keep her contact information current as required by law, and by ignoring these proceedings. Whatever the reason for that may be, it does not constitute good cause. Vacating the default judgment and returning this case to

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<sup>1</sup> To clarify the timing of Attorney Finnern's first contact with the Department: On Friday, February 20, she called the main Departmental number and was routed to Department Monitor, Michelle Schram. Ms. Schram was out of the office that day and Monday, February 23. (Affidavit of Michelle Schram, ¶ 3). Upon listening to Attorney Finnern's message for the first time on the morning of Tuesday, February 24, Ms. Schram promptly notified Division Attorney Joost Kap. *Id.* at ¶ 4. Within minutes, Attorney Kap emailed Attorney Finnern and immediately spoke with her via telephone, then followed up with another email attaching all relevant filings.

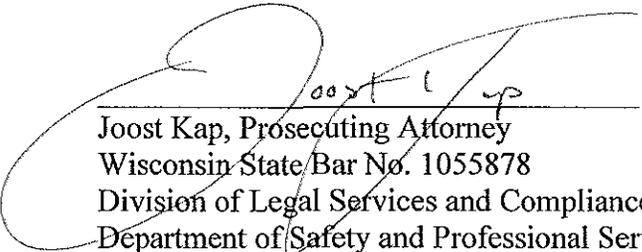
<sup>2</sup> The Division realizes that Respondent's motion was filed on short notice, but notes that none of the factual allegations are supported by affidavit or other evidence—in particular, statements about what Respondent did or did not receive.

Judge Nashold for additional pleadings, discovery and hearing would require that significant time, money and other resources would be spent by all; Respondent, the Division, Judge Nashold, and the complainant, Respondent's former employer, whose medical staff, administration, and patients would be deposed, and their records disclosed. And for what: so we can come back before the Board in six to eight months with the Division seeking the same discipline, and with the Respondent suffering the same issues she does now? The Board and Department have rules in place that apply to all licensees, with well-established consequences for failing to meet them. These rules would be weakened if respondents could wait until this stage of a proceeding only to have it start all over again. Respondent's failure to comply with these rules, under the given circumstances, is also further evidence as to why this matter needs to be addressed now.

### CONCLUSION

Respondent's motion to vacate default judgment should be denied. It was not timely filed and does not establish the requisite good cause. To vacate default would only impose great time and expense, needlessly postpone these proceedings, and delay the care that Respondent needs.

Dated this 3<sup>rd</sup> day of March, 2015.



Joost Kap, Prosecuting Attorney  
Wisconsin State Bar No. 1055878  
Division of Legal Services and Compliance  
Department of Safety and Professional Services  
P.O. Box 7190  
Madison, WI 53707-7190  
Tel. (608) 261-4464  
[Joost.Kap@wisconsin.gov](mailto:Joost.Kap@wisconsin.gov)

STATE OF WISCONSIN  
BEFORE THE MEDICAL EXAMINING BOARD

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IN THE MATTER OF :  
DISCIPLINARY PROCEEDINGS AGAINST :  
 : DHA Case No. SPS-14-0101  
NANETTE J. LIEGEOIS, M.D., : DLSC Case No. 14 MED 581  
RESPONDENT. :

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AFFIDAVIT OF BETH CRAMTON

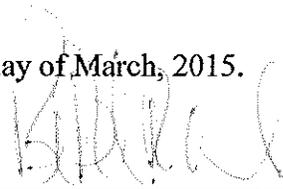
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STATE OF WISCONSIN            )  
  ) SS  
COUNTY OF DANE                )

Beth Cramton, being first duly sworn on oath, deposes and states as follows:

1. I am a paralegal for the Department of Safety and Professional Services, Division of Legal Services and Compliance (Division).
2. I make this affidavit on personal knowledge and in support of the Division's Brief Opposing Respondent's Motion to Vacate Default Judgment.
3. On December 18, 2014, I served Respondent with the Order for Summary Suspension via regular and certified mail, and by sending it to Respondent's email address of record with the Department: nanetteliegeois@gmail.com. A true and correct copy of that email is attached as Exhibit A.
4. On December 19, 2014, I served Respondent with the Notice of Hearing and Complaint in this matter via regular and certified mail, and by again sending it to Respondent's email address of record with the Department. A true and correct copy of that email is attached as Exhibit B.
5. I did not receive any error message or other response indicating that Respondent's email address was invalid or otherwise not receiving the emails I sent to her.

Dated in Madison, Wisconsin, this 2<sup>nd</sup> day of March, 2015.



---

Beth Cramton, Paralegal  
Department of Safety and Professional Services  
Division of Legal Services and Compliance

Subscribed and sworn to before me  
this 2<sup>nd</sup> day of March, 2015.



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Notary Public  
My Commission is permanent.



## Cramton, Beth - DSPS

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**From:** Cramton, Beth - DSPS  
**Sent:** Thursday, December 18, 2014 2:06 PM  
**To:** 'nanetteliegeois@gmail.com'  
**Cc:** Kap, Joost - DSPS  
**Subject:** DSPS Case No. 14 MED 581  
**Attachments:** 20141218121721995.pdf

Dear Dr. Liegeois:

Please take notice of the attached documents which are also being sent today via regular and certified mail to your address of record.

Sincerely,

Beth Cramton  
Paralegal  
Division of Legal Services and Compliance  
Tel. (608) 261-2380



**Cramton, Beth - DSPS**

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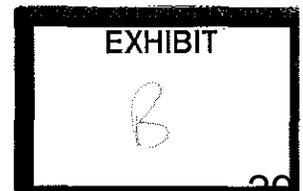
**From:** Cramton, Beth - DSPS  
**Sent:** Friday, December 19, 2014 9:51 AM  
**To:** 'nanetteliegeois@gmail.com'  
**Cc:** Kap, Joost - DSPS  
**Subject:** DSPS Case No. 14 MED 581  
**Attachments:** 20141219083656241.pdf

Dear Dr. Liegeois:

Please take notice of the attached documents which are also being sent today via regular and certified mail to your address of record.

Sincerely,

Beth Cramton  
Paralegal  
Division of Legal Services and Compliance  
Tel. (608) 261-2380



STATE OF WISCONSIN  
BEFORE THE MEDICAL EXAMINING BOARD

---

IN THE MATTER OF :  
DISCIPLINARY PROCEEDINGS AGAINST :  
NANETTE J. LIEGEOIS, M.D., : DHA Case No. SPS-14-0101  
RESPONDENT. : DLSC Case No. 14 MED 581

---

AFFIDAVIT OF MICHELLE SCHRAM

---

STATE OF WISCONSIN )  
 ) SS  
COUNTY OF DANE )

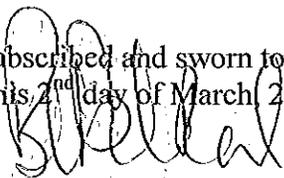
Michelle Schram, being first duly sworn on oath, deposes and states as follows:

1. I am the Monitor for the Department of Safety and Professional Services, Division of Legal Services and Compliance.
2. I make this affidavit on personal knowledge and in support of the Division's Brief Opposing Respondent's Motion to Vacate Default Judgment.
3. I was out of the office on Friday, February 20 and Monday, February 23, 2015.
4. I returned to the office on Tuesday, February 24, and listened to my voicemails, including one about this matter from Attorney Christianna Finnern. I promptly notified Attorney Joost Kap of Attorney Finnern's message, and he stated he would respond.

Dated in Madison, Wisconsin, this 2<sup>nd</sup> day of March, 2015.

  
Michelle Schram, Department Monitor  
Department of Safety and Professional Services  
Division of Legal Services and Compliance

Subscribed and sworn to before me  
This 2<sup>nd</sup> day of March, 2015.

  
Notary Public Expires 3-27-2016  
My Commission is permanent.

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

|  |   |   |  |
|--|---|---|--|
| 1) Name and Title of Person Submitting the Request:<br><br>Taylor Thompson, Bureau Assistant<br>on behalf of<br>Tom Ryan, Executive Director   |   | 2) Date When Request Submitted:<br><br>2/27/15<br>Items will be considered late if submitted after 12:00 p.m. on the deadline date:<br>▪ 8 business days before the meeting |  |
| 3) Name of Board, Committee, Council, Sections:<br><br>Medical Examining Board   |   |   |  |
| 4) Meeting Date:<br><br>3/18/15  | 5) Attachments:<br><input checked="" type="checkbox"/> Yes<br><input type="checkbox"/> No   | 6) How should the item be titled on the agenda page?<br><br>FSMB Matters:<br>Interstate Medical Licensure Compact   |  |
| 7) Place Item in:<br><input checked="" type="checkbox"/> Open Session<br><input type="checkbox"/> Closed Session<br><input type="checkbox"/> Both  | 8) Is an appearance before the Board being scheduled?<br><br><input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> )<br><input checked="" type="checkbox"/> No | 9) Name of Case Advisor(s), if required:  |  |
| 10) Describe the issue and action that should be addressed:  |   |   |  |
| 11) Authorization  |   |   |  |
| <b>Taylor Thompson</b>   |   | <b>2/27/15</b>  |  |
| Signature of person making this request  |   | Date  |  |
| Supervisor (if required)   |   | Date  |  |
| Executive Director signature (indicates approval to add post agenda deadline item to agenda)    Date   |   |   |  |
| Directions for including supporting documents:<br>1. This form should be attached to any documents submitted to the agenda.<br>2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director.<br>3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting. |   |   |  |

Board: Here's a list of issues I see with the proposed Compact that I think need to be resolved prior to Wisconsin signing on. Issues #20 and #8 below are probably the most problematic from a "citizen of Wisconsin" standpoint. I've attached the original .pdf with my notes for reference and a clean copy of the compact for comparison. I apologize in advance for the nature and length of these comments. They require reading and rereading of the proposed Compact to understand potential impact. I personally don't think this compact has been well thought through nor is it well-articulated, particularly from a states rights standpoint. I personally believe that Wisconsin should keep its powder dry until these issues have been satisfactorily addressed.

Specific issues in no specific order of importance:

1. There is no definition of "disciplinary action" contained within Section 2 definitions. - Applicable to Section 10 which contemplates reciprocal discipline and to Section 7 for expedited license renewal. Since states have differing definitions of "discipline", any compact will have to define "discipline" for all.
2. Section 5(b) is a series of paragraphs that apply responsibilities of the selected state of principle licensure yet inexplicably Section 5(b)(i) is a paragraph that applies to non-principle licensure states. Should be located elsewhere in the document.
3. Section 5(b)(ii) requires fingerprinting or biometric data for application. A new requirement not yet necessary in Wisconsin.
4. Section 5(c) specifies receiving a license in the "principal" state upon payment of fees. Section 5(d) makes it sound as if this payment of fees is to the principal state. But Section 5(c) could be interpreted as the Interstate Commission. Which is it?
5. Section 5(d) presumably applies to "non-principal states" but is specifies that after verification under 5(b) in the principal state and payment of fess to the principal state in 5(c) the "member board" SHALL ISSUE ... in convoluted language, I believe this section applies that the "principal" state, not the "non-principal" states.
6. Section 3(b) defines eligibility as subject to Section 2(k) which states in (2)(k)(7) that the applicant MUST already possess a full and unrestricted license. So a compact license can only be granted after a state, presumably the one which will be selected as the principle state, has granted a license. Yet the principal state in Section 5 must verify eligibility ... Basically this means that applicants must first obtain a regular unrestricted license after paying appropriate licensure and application fees to the "principal" state. They then begin the expedited licensure process, presumably using their just issued license as the "principal" state. They again pay expedited licensure fees to the "principal" state to initiate an expedited licensure process ... then the "principal" state SHALL ISSUE [per Section 5(d)] a license it has already issued. Just plain DUMB.
7. Section 5(f) creates a nightmare for member states when a physician allows his/her license to lapse in the "principal" state. Yet each state has different methods of handling lapsed licenses. If revocation in all states must follow

- principal license lapse, does Wisconsin need to create a new class of license that is not subject to renewal (the 5 year grace period we currently have in place)?
8. Sections 5(g), 6(b), 7(f), 8(g), 12(b), and 15 explicitly allows the Commission to develop [and presumably enact] rules for various aspects of expedited licensure. And Section 24(c) says these rules and bylaws are BINDING on the member states. Is there no right of review by member states to determine impact at the individual state level? What if the created rules specify fees below our cost to provide the expedited licensing service? Argues that a separate class of license be created in Wisconsin so we're not continually changing our non-expedited processes in reaction ...
  9. Section 7(c) says the Commission will collect renewal fees, presumably to subsequently be passed on to the member state issuing the license. Is any of the fee kept by the Commission to, say, cover its operating costs?
  10. Section 7(d) says upon receipt of fees in 7(c) ... is this receipt of fees by the Commission or by the member state? In other words, since 7(c) says Commission receives fees, does 7(d) require member states to issue renewals prior to receipt of fees in the member state?
  11. Section 8(a) says Commission will establish a database ... who funds this?
  12. Section 8(b) says member states are required to report any "public action or complaints" (expedited licensees only or all licensees?). What about unsubstantiated complaints? Initial complaints are complaints ... No complaint is ever public so does Wisconsin get a pass on this one? Do we need to create a Wisconsin rule defining a public vs. a non-public complaint?
  13. Section 8(c) requires member boards to report disciplinary or investigatory info (expedited licensees only or everyone?) to the Commission based on an as yet unannounced set of rules to be promulgated by the Commission. Sounds like a blank check to me.
  14. Section 8(e) compels member boards to share complaint or disciplinary info upon request. Public or non-public complaints? All licensees within a state or only expedited licensees?
  15. What does section 9(a) mean ... "deemed investigative". And is there a limit - expedited licenses or all?
  16. Need a lawyer to answer this: Section 9(c) ... is this legal in Wisconsin? What standing does an Interstate Commission have to subpoena a licensee (and presumably a resident) of Wisconsin?
  17. Does the infestation right enumerated under Section 8(e) apply to standard licenses as well as expedited licenses? And what resources do member states bring to bear to understand the statutes authorizing the practice of medicine in another member state?
  18. Section 9(d) provides for automatic suspension of ANY license in ALL member state when ANY member board when a license is surrendered (only in lieu of discipline) or suspended. The automatic suspension SHALL be for 90 days. Do we, DSPS, have the wherewithal to evaluate actions by another state and adjudicate within Wisconsin statutes in the requisite 90 days?

19. Section 12(d) gives the Commission power to enforce compliance with the Compact provisions, rules, etc. OK. Who funds this enforcement? Does the “non-compliant” state compelled to pay for its own prosecution?
20. Section 12(e)-(o) give the Commission extraordinary financial power to govern its activities. These are further elucidated in Section 13. Section 13 grants power to the Commission to “levy on and collect an annual assessment from each member state to cover costs of operations and activities.” Further this assessment SHALL be allocated upon by a formula as yet undetermined. Sounds to me like a blank check. In the extreme the Commission could say: “Let’s gang up on Wisconsin this year and have them pay 90% of the operating costs; the other member states in aggregate get to pay only 10%”. The only out for this egregious assessment is covered by Section 21 that specifies a one year notice must be given FOLLOWING enactment of a statute repealing membership in the Compact (which itself might take a couple of years to accomplish). Until that withdrawal is effective, member states remain financially obligated to fund the blank check ...
21. Compact begins with at least 7 member states [Section 20(b)] agreeing to participate in the compact but survives until only one member state remains [22(a)]. I personally think the dissolution should occur sooner, perhaps when the requisite 7 are no longer participating.
22. What becomes of the assets of the Commission upon dissolution? Again, a blank check.
23. Section 24(b) says that all Wisconsin laws are surrogated to the Compact when a conflict occurs. Compact wins without negotiation. Only recourse is withdrawal from the compact and that’s tough to do.

Timothy L Swan, MD



**DATE:** January 28, 2015

**TO:** Member Medical Board Executive Directors –  
Interstate Medical Licensure Compact Supporters

**FROM:** Humayun J. Chaudhry, DO, MACP  
FSMB President and CEO

**CC:** Don Polk, DO, FSMB Chair  
FSMB Board of Directors

**RE:** Interstate Medical Licensure Compact Misinformation

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The Federation of State Medical Boards (FSMB) has become aware in recent days of an effort being conducted by various individuals to undermine the Interstate Medical Licensure Compact.

This memorandum is being sent to the Executive Directors of those state medical and osteopathic boards that have formally endorsed or supported the Compact. It lists the concerns of those opposed to the Compact and refutes each of the misrepresentations and falsehoods that we have heard. Please feel free to share these with your state board members, state legislators and state medical and osteopathic societies, as appropriate.

As you know, the Compact was put together by representatives of several state boards and has been endorsed by physician organizations such as the American Medical Association (AMA) and by 25 state medical and osteopathic boards in just the few short months since it was introduced. It provides a reasonable, innovative way to get more physicians licensed in the states where their services are vitally needed – while preserving all of the protections of state-based medical regulation and allowing physicians the freedom to choose the licensing path that works best for them. The Compact has already been introduced in 10 state legislatures (Iowa, Minnesota, Nebraska, Oklahoma, South Dakota, Texas, Utah, Vermont, West Virginia, and Wyoming).

There have been false and misleading public statements and distortions made about the Compact in an effort to discredit it and help thwart its adoption by state legislatures. Ironically, such an effort empowers those that favor a national approach to medical licensure.

The anti-Compact campaign is riddled with falsehoods that are easily debunked by simply reading the model legislation that was crafted in an open and collaborative fashion by the state medical boards with input from stakeholders across the nation. Perhaps the most egregious of these falsehoods is the notion that the Compact would somehow force practicing physicians to participate in additional levels of medical certification beyond basic licensing and standard requirements for continuing medical education (CME).

Participation in the proposed Compact is totally optional, and is intended only for those physicians who wish to practice in multiple states and who want to avoid the process of applying for multiple state licenses one at a time. It in no way changes the requirements for state medical licensure for physicians seeking one license within a state or for those who choose to become licensed in multiple states through existing processes. The status quo remains, for any physician who wants to continue to use current licensing processes.

The FSMB has prepared a fact sheet about “Six Myths About the Compact”, outlined below, that refutes the misleading claims.. The fact sheet will also soon be available at the FSMB’s Interstate Medical Licensure Compact website ([www.licenseportability.org](http://www.licenseportability.org)).

### **SIX MYTHS ABOUT THE INTERSTATE MEDICAL LICENSURE COMPACT**

*MYTH: It is alleged that the definition of a physician in the Compact is at variance with the definition of a physician by all other state medical boards.*

**FACT:** The definition of a physician in the Interstate Compact relates only to the eligibility to receive a license through the process outlined in the Compact. The Compact definition does not change the existing definition of a physician in a state’s existing Medical Practice Act, nor does it change the basic requirements for state medical licensure of a physician seeking only one license within a state or who chooses to become licensed in additional states through existing processes.

**FACT:** In order for the Compact to be acceptable in ALL states, the definition of a physician was drafted by state medical boards in a manner that meets the highest standards already required for expedited licensure or licensure by endorsement (many states already have standards in place for expedited licensure or licensure by endorsement that require specialty-board certification.)

**FACT:** Physicians who do not meet the requirements, including those not specialty certified, are still eligible to apply for state medical licensure in a member state through the current process. Initial estimates show that up to 80% of licensed physicians in the U.S. are currently eligible to participate in the Compact, if they choose to do so.

*MYTH: It is alleged that physicians participating in the Compact would be required to participate in Maintenance of Certification (MOC), or that MOC is an eligibility requirement for the Compact.*

**FACT:** The Compact makes absolutely no reference to Maintenance of Certification (MOC) or its osteopathic counterpart, Osteopathic Continuous Certification (OCC). The Compact does not require a physician to participate in MOC, nor does it require or even make mention of the need to participate in MOC as a licensure renewal requirement in any state. Once a physician is issued a license via the Compact from a state, he or she must adhere (as now) to the renewal and continuing medical education requirements of that state. No state requires MOC as a condition for licensure renewal, and therefore, this will not be required for physicians participating in the Compact.

*MYTH: It is claimed that the Compact would "supersede a state's authority and control over the practice of medicine."*

**FACT:** The Compact reflects the effort of the state medical boards to develop a dynamic, self-regulatory system of expedited state medical licensure over which the participating states maintain control through a coordinated legislative and administrative process. Coordination through a compact is not the same as commandeering state authority. It is the ultimate expression of state authority.

**FACT:** Some of the groups that are distorting the facts about the Compact are contradicting their own policies and goals: The American Legislative Exchange Council (ALEC), for example, which is now criticizing the Compact, has supported interstate compacts as solutions to other multi-state-based legislative challenges in the past.

*MYTH: It is claimed that the Compact would change a state's Medical Practice Act.*

**FACT:** The Compact clearly states that it would not change a state's Medical Practice Act. From the Compact's preamble: "The Compact creates another pathway for licensure and does not otherwise change a state's existing Medical Practice Act."

**FACT:** The Compact also adopts the prevailing standard for state medical licensure found in the Medical Practice Acts of each state, affirming that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter.

*MYTH: It is asserted that it would be expensive for a state to extricate itself from the Interstate Medical Licensure Compact.*

**FACT:** State participation in the Compact is, and will remain, voluntary. States are free to withdraw from the Compact and may do so by repealing the enacted statute. The withdrawal provisions of the Interstate Compact are consistent with interstate compacts currently enacted throughout the country.

*MYTH: It is claimed that the Compact represents a regulatory excess, and costs and burdens on the state will be increased.*

**FACT:** The process of licensure proposed in the Compact would reduce costs, streamlining the process for licensees. Rather than having to obtain individual documents for multiple states, which is both expensive and time consuming, member states can rely on verified, shared information to speed the licensee through the licensing process. Licensees would have to pay the fees set by their state in order to obtain and maintain a license via the Compact, just as with licenses currently obtained via current methods. The Compact is not an example of regulatory excess but an example of regulatory common sense.

For more information about the Compact, visit [www.licenseportability.org](http://www.licenseportability.org).

**About the Federation of State Medical Boards:** The Federation of State Medical Boards (FSMB) is a national non-profit organization representing all medical boards within the United States and its territories that license and discipline allopathic and osteopathic physicians and, in some jurisdictions, other health care professionals. FSMB leads by promoting excellence in medical practice, licensure and regulation as the national resource and voice on behalf of state medical boards in their protection of the public. To learn more about FSMB visit: <http://www.fsmb.org/>. You can also follow FSMB on Twitter (@theFSMB and @FSMBPolicy) and Facebook by liking the Federation of State Medical Boards page.

**INTERSTATE MEDICAL LICENSURE COMPACT**



1 **INTERSTATE MEDICAL LICENSURE COMPACT**

2 **SECTION 1. PURPOSE**

3 In order to strengthen access to health care, and in recognition of the advances in the delivery of  
4 health care, the member states of the Interstate Medical Licensure Compact have allied in  
5 common purpose to develop a comprehensive process that complements the existing licensing  
6 and regulatory authority of state medical boards, provides a streamlined process that allows  
7 physicians to become licensed in multiple states, thereby enhancing the portability of a medical  
8 license and ensuring the safety of patients. The Compact creates another pathway for licensure  
9 and does not otherwise change a state's existing Medical Practice Act. The Compact also adopts  
10 the prevailing standard for licensure and affirms that the practice of medicine occurs where the  
11 patient is located at the time of the physician-patient encounter, and therefore, requires the  
12 physician to be under the jurisdiction of the state medical board where the patient is located.  
13 State medical boards that participate in the Compact retain the jurisdiction to impose an adverse  
14 action against a license to practice medicine in that state issued to a physician through the  
15 procedures in the Compact.

16  
17 **SECTION 2. DEFINITIONS**

18 In this compact:

19 (a) "Bylaws" means those bylaws established by the Interstate Commission pursuant to  
20 Section 11 for its governance, or for directing and controlling its actions and conduct.

21 (b) "Commissioner" means the voting representative appointed by each member board  
22 pursuant to Section 11.

23 (c) "Conviction" means a finding by a court that an individual is guilty of a criminal  
24 offense through adjudication, or entry of a plea of guilt or no contest to the charge by the

1 offender. Evidence of an entry of a conviction of a criminal offense by the court shall be  
2 considered final for purposes of disciplinary action by a member board.

3 (d) "Expedited License" means a full and unrestricted medical license granted by a  
4 member state to an eligible physician through the process set forth in the Compact.

5 (e) "Interstate Commission" means the interstate commission created pursuant to Section  
6 11.

7 (f) "License" means authorization by a state for a physician to engage in the practice of  
8 medicine, which would be unlawful without the authorization.

9 (g) "Medical Practice Act" means laws and regulations governing the practice of  
10 allopathic and osteopathic medicine within a member state.

11 (h) "Member Board" means a state agency in a member state that acts in the sovereign  
12 interests of the state by protecting the public through licensure, regulation, and education of  
13 physicians as directed by the state government.

14 (i) "Member State" means a state that has enacted the Compact.

15 (j) "Practice of Medicine" means the clinical prevention, diagnosis, or treatment of  
16 human disease, injury, or condition requiring a physician to obtain and maintain a license in  
17 compliance with the Medical Practice Act of a member state.

18 (k) "Physician" means any person who:

19 (1) Is a graduate of a medical school accredited by the Liaison Committee on  
20 Medical Education, the Commission on Osteopathic College Accreditation, or a medical school  
21 listed in the International Medical Education Directory or its equivalent;

22 (2) Passed each component of the United States Medical Licensing Examination  
23 (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA)

1 within three attempts, or any of its predecessor examinations accepted by a state medical board  
2 as an equivalent examination for licensure purposes;

3 (3) Successfully completed graduate medical education approved by the  
4 Accreditation Council for Graduate Medical Education or the American Osteopathic  
5 Association;

6 (4) Holds specialty certification or a time-unlimited specialty certificate recognized  
7 by the American Board of Medical Specialties or the American Osteopathic Association's  
8 Bureau of Osteopathic Specialists;

9 (5) Possesses a full and unrestricted license to engage in the practice of medicine  
10 issued by a member board;

11 (6) Has never been convicted, received adjudication, deferred adjudication,  
12 community supervision, or deferred disposition for any offense by a court of appropriate  
13 jurisdiction;

14 (7) Has never held a license authorizing the practice of medicine subjected to  
15 discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action  
16 related to non-payment of fees related to a license;

17 (8) Has never had a controlled substance license or permit suspended or revoked by  
18 a state or the United States Drug Enforcement Administration; and

19 (9) Is not under active investigation by a licensing agency or law enforcement  
20 authority in any state, federal, or foreign jurisdiction.

21 (l) "Offense" means a felony, gross misdemeanor, or crime of moral turpitude.

22 (m) "Rule" means a written statement by the Interstate Commission promulgated  
23 pursuant to Section 12 of the Compact that is of general applicability, implements, interprets, or

1 prescribes a policy or provision of the Compact, or an organizational, procedural, or practice  
2 requirement of the Interstate Commission, and has the force and effect of statutory law in a  
3 member state, and includes the amendment, repeal, or suspension of an existing rule.

4 (n) "State" means any state, commonwealth, district, or territory of the United States.

5 (o) "State of Principal License" means a member state where a physician holds a license  
6 to practice medicine and which has been designated as such by the physician for purposes of  
7 registration and participation in the Compact.

8  
9 **SECTION 3. ELIGIBILITY**

10 (a) A physician must meet the eligibility requirements as defined in Section 2(k) to  
11 receive an expedited license under the terms and provisions of the Compact.

12 (b) A physician who does not meet the requirements of Section 2(k) may obtain a license  
13 to practice medicine in a member state if the individual complies with all laws and requirements,  
14 other than the Compact, relating to the issuance of a license to practice medicine in that state.

15  
16 **SECTION 4. DESIGNATION OF STATE OF PRINCIPAL LICENSE**

17 (a) A physician shall designate a member state as the state of principal license for  
18 purposes of registration for expedited licensure through the Compact if the physician possesses a  
19 full and unrestricted license to practice medicine in that state, and the state is:

- 20 (1) the state of primary residence for the physician, or  
21 (2) the state where at least 25% of the practice of medicine occurs, or  
22 (3) the location of the physician's employer, or  
23 (4) if no state qualifies under subsection (1), subsection (2), or subsection (3), the

1 state designated as state of residence for purpose of federal income tax.

2 (b) A physician may redesignate a member state as state of principal license at any time,  
3 as long as the state meets the requirements in subsection (a).

4 (c) The Interstate Commission is authorized to develop rules to facilitate redesignation of  
5 another member state as the state of principal license.

6  
7 **SECTION 5. APPLICATION AND ISSUANCE OF EXPEDITED LICENSURE**

8 (a) A physician seeking licensure through the Compact shall file an application for an  
9 expedited license with the member board of the state selected by the physician as the state of  
10 principal license.

11 (b) Upon receipt of an application for an expedited license, the member board within the  
12 state selected as the state of principal license shall evaluate whether the physician is eligible for  
13 expedited licensure and issue a letter of qualification, verifying or denying the physician's  
14 eligibility, to the Interstate Commission.

15 (i) Static qualifications, which include verification of medical education, graduate  
16 medical education, results of any medical or licensing examination, and other qualifications as  
17 determined by the Interstate Commission through rule, shall not be subject to additional primary  
18 source verification where already primary source verified by the state of principal license.

19 (ii) The member board within the state selected as the state of principal license  
20 shall, in the course of verifying eligibility, perform a criminal background check of an applicant,  
21 including the use of the results of fingerprint or other biometric data checks compliant with the  
22 requirements of the Federal Bureau of Investigation, with the exception of federal employees who  
23 have suitability determination in accordance with U.S. C.F.R. §731.202.

24 (iii) Appeal on the determination of eligibility shall be made to the member state

1 where the application was filed and shall be subject to the law of that state.

2 (c) Upon verification in subsection (b), physicians eligible for an expedited license shall  
3 complete the registration process established by the Interstate Commission to receive a license in  
4 a member state selected pursuant to subsection (a), including the payment of any applicable  
5 fees.

6 (d) After receiving verification of eligibility under subsection (b) and any fees under  
7 subsection (c), a member board shall issue an expedited license to the physician. This license  
8 shall authorize the physician to practice medicine in the issuing state consistent with the Medical  
9 Practice Act and all applicable laws and regulations of the issuing member board and member  
10 state.

11 (e) An expedited license shall be valid for a period consistent with the licensure period in  
12 the member state and in the same manner as required for other physicians holding a full and  
13 unrestricted license within the member state.

14 (f) An expedited license obtained through the Compact shall be terminated if a physician  
15 fails to maintain a license in the state of principal licensure for a non-disciplinary reason, without  
16 redesignation of a new state of principal licensure.

17 (g) The Interstate Commission is authorized to develop rules regarding the application  
18 process, including payment of any applicable fees, and the issuance of an expedited license.

19  
20 **SECTION 6. FEES FOR EXPEDITED LICENSURE**

21 (a) A member state issuing an expedited license authorizing the practice of medicine in  
22 that state may impose a fee for a license issued or renewed through the Compact.

23 (b) The Interstate Commission is authorized to develop rules regarding fees for expedited

1 licenses.

2

3 **SECTION 7. RENEWAL AND CONTINUED PARTICIPATION**

4 (a) A physician seeking to renew an expedited license granted in a member state shall  
5 complete a renewal process with the Interstate Commission if the physician:

6 (1) Maintains a full and unrestricted license in a state of principal license;

7 (2) Has not been convicted, received adjudication, deferred adjudication,  
8 community supervision, or deferred disposition for any offense by a court of appropriate  
9 jurisdiction;

10 (3) Has not had a license authorizing the practice of medicine subject to discipline  
11 by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to  
12 non-payment of fees related to a license; and

13 (4) Has not had a controlled substance license or permit suspended or revoked by  
14 a state or the United States Drug Enforcement Administration.

15 (b) Physicians shall comply with all continuing professional development or continuing  
16 medical education requirements for renewal of a license issued by a member state.

17 (c) The Interstate Commission shall collect any renewal fees charged for the renewal of  
18 a license and distribute the fees to the applicable member board.

19 (d) Upon receipt of any renewal fees collected in subsection (c), a member board shall  
20 renew the physician's license.

21 (e) Physician information collected by the Interstate Commission during the renewal  
22 process will be distributed to all member boards.

23 (f) The Interstate Commission is authorized to develop rules to address renewal of

1 licenses obtained through the Compact.

2

3 **SECTION 8. COORDINATED INFORMATION SYSTEM**

4

5 (a) The Interstate Commission shall establish a database of all physicians licensed, or  
6 who have applied for licensure, under Section 5.

7

8 (b) Notwithstanding any other provision of law, member boards shall report to the  
9 Interstate Commission any public action or complaints against a licensed physician who has  
10 applied or received an expedited license through the Compact.

11

12 (c) Member boards shall report disciplinary or investigatory information determined as  
13 necessary and proper by rule of the Interstate Commission.

14

15 (d) Member boards may report any non-public complaint, disciplinary, or investigatory  
16 information not required by subsection (c) to the Interstate Commission.

17

18 (e) Member boards shall share complaint or disciplinary information about a physician  
19 upon request of another member board.

20

21 (f) All information provided to the Interstate Commission or distributed by member  
22 boards shall be confidential, filed under seal, and used only for investigatory or disciplinary  
23 matters.

24

25 (g) The Interstate Commission is authorized to develop rules for mandated or  
discretionary sharing of information by member boards.

26

27 **SECTION 9. JOINT INVESTIGATIONS**

28

29 (a) Licensure and disciplinary records of physicians are deemed investigative.

30

31 (b) In addition to the authority granted to a member board by its respective Medical

32

Practice Act or other applicable state law, a member board may participate with other member

1 boards in joint investigations of physicians licensed by the member boards.

2 (c) A subpoena issued by a member state shall be enforceable in other member states.

3 (d) Member boards may share any investigative, litigation, or compliance materials in  
4 furtherance of any joint or individual investigation initiated under the Compact.

5 (e) Any member state may investigate actual or alleged violations of the statutes  
6 authorizing the practice of medicine in any other member state in which a physician holds a  
7 license to practice medicine.

8

9 **SECTION 10. DISCIPLINARY ACTIONS**

10 (a) Any disciplinary action taken by any member board against a physician licensed  
11 through the Compact shall be deemed unprofessional conduct which may be subject to discipline  
12 by other member boards, in addition to any violation of the Medical Practice Act or regulations  
13 in that state.

14 (b) If a license granted to a physician by the member board in the state of principal  
15 license is revoked, surrendered or relinquished in lieu of discipline, or suspended, then all  
16 licenses issued to the physician by member boards shall automatically be placed, without further  
17 action necessary by any member board, on the same status. If the member board in the state of  
18 principal license subsequently reinstates the physician's license, a license issued to the  
19 physician by any other member board shall remain encumbered until that respective member  
20 board takes action to reinstate the license in a manner consistent with the Medical Practice Act of  
21 that state.

22 (c) If disciplinary action is taken against a physician by a member board not in the state  
23 of principal license, any other member board may deem the action conclusive as to matter of law

1 and fact decided, and:

2 (i) impose the same or lesser sanction(s) against the physician so long as such  
3 sanctions are consistent with the Medical Practice Act of that state;

4 (ii) or pursue separate disciplinary action against the physician under its  
5 respective Medical Practice Act, regardless of the action taken in other member states.

6 (d) If a license granted to a physician by a member board is revoked, surrendered or  
7 relinquished in lieu of discipline, or suspended, then any license(s) issued to the physician by any  
8 other member board(s) shall be suspended, automatically and immediately without further action  
9 necessary by the other member board(s), for ninety (90) days upon entry of the order by the  
10 disciplining board, to permit the member board(s) to investigate the basis for the action under the  
11 Medical Practice Act of that state. A member board may terminate the automatic suspension of  
12 the license it issued prior to the completion of the ninety (90) day suspension period in a manner  
13 consistent with the Medical Practice Act of that state.

14

15 **SECTION 11. INTERSTATE MEDICAL LICENSURE COMPACT**

16 **COMMISSION**

17 (a) The member states hereby create the "Interstate Medical Licensure Compact  
18 Commission".

19 (b) The purpose of the Interstate Commission is the administration of the Interstate  
20 Medical Licensure Compact, which is a discretionary state function.

21 (c) The Interstate Commission shall be a body corporate and joint agency of the member  
22 states and shall have all the responsibilities, powers, and duties set forth in the Compact, and  
23 such additional powers as may be conferred upon it by a subsequent concurrent action of the

1 respective legislatures of the member states in accordance with the terms of the Compact.

2 (d) The Interstate Commission shall consist of two voting representatives appointed by  
3 each member state who shall serve as Commissioners. In states where allopathic and osteopathic  
4 physicians are regulated by separate member boards, or if the licensing and disciplinary authority  
5 is split between multiple member boards within a member state, the member state shall appoint  
6 one representative from each member board. A Commissioner shall be a(n):

7 (1) Allopathic or osteopathic physician appointed to a member board;

8 (2) Executive director, executive secretary, or similar executive of a member  
9 board; or

10 (3) Member of the public appointed to a member board.

11 (e) The Interstate Commission shall meet at least once each calendar year. A portion of  
12 this meeting shall be a business meeting to address such matters as may properly come before the  
13 Commission, including the election of officers. The chairperson may call additional meetings  
14 and shall call for a meeting upon the request of a majority of the member states.

15 (f) The bylaws may provide for meetings of the Interstate Commission to be conducted  
16 by telecommunication or electronic communication.

17 (g) Each Commissioner participating at a meeting of the Interstate Commission is entitled  
18 to one vote. A majority of Commissioners shall constitute a quorum for the transaction of  
19 business, unless a larger quorum is required by the bylaws of the Interstate Commission. A  
20 Commissioner shall not delegate a vote to another Commissioner. In the absence of its  
21 Commissioner, a member state may delegate voting authority for a specified meeting to another  
22 person from that state who shall meet the requirements of subsection (d).

23 (h) The Interstate Commission shall provide public notice of all meetings and all

1 meetings shall be open to the public. The Interstate Commission may close a meeting, in full or  
2 in portion, where it determines by a two-thirds vote of the Commissioners present that an open  
3 meeting would be likely to:

4 (1) Relate solely to the internal personnel practices and procedures of the  
5 Interstate Commission;

6 (2) Discuss matters specifically exempted from disclosure by federal statute;

7 (3) Discuss trade secrets, commercial, or financial information that is privileged  
8 or confidential;

9 (4) Involve accusing a person of a crime, or formally censuring a person;

10 (5) Discuss information of a personal nature where disclosure would constitute a  
11 clearly unwarranted invasion of personal privacy;

12 (6) Discuss investigative records compiled for law enforcement purposes; or

13 (7) Specifically relate to the participation in a civil action or other legal  
14 proceeding.

15 (i) The Interstate Commission shall keep minutes which shall fully describe all matters  
16 discussed in a meeting and shall provide a full and accurate summary of actions taken, including  
17 record of any roll call votes.

18 (j) The Interstate Commission shall make its information and official records, to the  
19 extent not otherwise designated in the Compact or by its rules, available to the public for  
20 inspection.

21 (k) The Interstate Commission shall establish an executive committee, which shall  
22 include officers, members, and others as determined by the bylaws. The executive committee  
23 shall have the power to act on behalf of the Interstate Commission, with the exception of

1 rulemaking, during periods when the Interstate Commission is not in session. When acting on  
2 behalf of the Interstate Commission, the executive committee shall oversee the administration of  
3 the Compact including enforcement and compliance with the provisions of the Compact, its  
4 bylaws and rules, and other such duties as necessary.

5 (l) The Interstate Commission may establish other committees for governance and  
6 administration of the Compact.

7

8 **SECTION 12. POWERS AND DUTIES OF THE INTERSTATE COMMISSION**

9 The Interstate Commission shall have the duty and power to:

10 (a) Oversee and maintain the administration of the Compact;

11 (b) Promulgate rules which shall be binding to the extent and in the manner provided for  
12 in the Compact;

13 (c) Issue, upon the request of a member state or member board, advisory opinions  
14 concerning the meaning or interpretation of the Compact, its bylaws, rules, and actions;

15 (d) Enforce compliance with Compact provisions, the rules promulgated by the Interstate  
16 Commission, and the bylaws, using all necessary and proper means, including but not limited to  
17 the use of judicial process;

18 (e) Establish and appoint committees including, but not limited to, an executive  
19 committee as required by Section 11, which shall have the power to act on behalf of the  
20 Interstate Commission in carrying out its powers and duties;

21 (f) Pay, or provide for the payment of the expenses related to the establishment,  
22 organization, and ongoing activities of the Interstate Commission;

23 (g) Establish and maintain one or more offices;

24 (h) Borrow, accept, hire, or contract for services of personnel;

- 1 (i) Purchase and maintain insurance and bonds;
- 2 (j) Employ an executive director who shall have such powers to employ, select or appoint  
3 employees, agents, or consultants, and to determine their qualifications, define their duties, and  
4 fix their compensation;
- 5 (k) Establish personnel policies and programs relating to conflicts of interest, rates of  
6 compensation, and qualifications of personnel;
- 7 (l) Accept donations and grants of money, equipment, supplies, materials and services,  
8 and to receive, utilize, and dispose of it in a manner consistent with the conflict of interest  
9 policies established by the Interstate Commission;
- 10 (m) Lease, purchase, accept contributions or donations of, or otherwise to own, hold,  
11 improve or use, any property, real, personal, or mixed;
- 12 (n) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any  
13 property, real, personal, or mixed;
- 14 (o) Establish a budget and make expenditures;
- 15 (p) Adopt a seal and bylaws governing the management and operation of the Interstate  
16 Commission;
- 17 (q) Report annually to the legislatures and governors of the member states concerning the  
18 activities of the Interstate Commission during the preceding year. Such reports shall also include  
19 reports of financial audits and any recommendations that may have been adopted by the  
20 Interstate Commission;
- 21 (r) Coordinate education, training, and public awareness regarding the Compact, its  
22 implementation, and its operation;
- 23 (s) Maintain records in accordance with the bylaws;

1 (t) Seek and obtain trademarks, copyrights, and patents; and

2 (u) Perform such functions as may be necessary or appropriate to achieve the purposes of  
3 the Compact.

4  
5 **SECTION 13. FINANCE POWERS**

6 (a) The Interstate Commission may levy on and collect an annual assessment from each  
7 member state to cover the cost of the operations and activities of the Interstate Commission and  
8 its staff. The total assessment must be sufficient to cover the annual budget approved each year  
9 for which revenue is not provided by other sources. The aggregate annual assessment amount  
10 shall be allocated upon a formula to be determined by the Interstate Commission, which shall  
11 promulgate a rule binding upon all member states.

12 (b) The Interstate Commission shall not incur obligations of any kind prior to securing  
13 the funds adequate to meet the same.

14 (c) The Interstate Commission shall not pledge the credit of any of the member states,  
15 except by, and with the authority of, the member state.

16 (d) The Interstate Commission shall be subject to a yearly financial audit conducted by a  
17 certified or licensed public accountant and the report of the audit shall be included in the annual  
18 report of the Interstate Commission.

19  
20 **SECTION 14. ORGANIZATION AND OPERATION OF THE INTERSTATE**  
21 **COMMISSION**

22 (a) The Interstate Commission shall, by a majority of Commissioners present and voting,  
23 adopt bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes

1 of the Compact within twelve (12) months of the first Interstate Commission meeting.

2 (b) The Interstate Commission shall elect or appoint annually from among its  
3 Commissioners a chairperson, a vice-chairperson, and a treasurer, each of whom shall have such  
4 authority and duties as may be specified in the bylaws. The chairperson, or in the chairperson's  
5 absence or disability, the vice-chairperson, shall preside at all meetings of the Interstate  
6 Commission.

7 (c) Officers selected in subsection (b) shall serve without remuneration from the  
8 Interstate Commission.

9 (d) The officers and employees of the Interstate Commission shall be immune from suit  
10 and liability, either personally or in their official capacity, for a claim for damage to or loss of  
11 property or personal injury or other civil liability caused or arising out of, or relating to, an actual  
12 or alleged act, error, or omission that occurred, or that such person had a reasonable basis for  
13 believing occurred, within the scope of Interstate Commission employment, duties, or  
14 responsibilities; provided that such person shall not be protected from suit or liability for  
15 damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of  
16 such person.

17 (1) The liability of the executive director and employees of the Interstate  
18 Commission or representatives of the Interstate Commission, acting within the scope of such  
19 person's employment or duties for acts, errors, or omissions occurring within such person's state,  
20 may not exceed the limits of liability set forth under the constitution and laws of that state for  
21 state officials, employees, and agents. The Interstate Commission is considered to be an  
22 instrumentality of the states for the purposes of any such action. Nothing in this subsection shall  
23 be construed to protect such person from suit or liability for damage, loss, injury, or liability

1 caused by the intentional or willful and wanton misconduct of such person.

2 (2) The Interstate Commission shall defend the executive director, its employees,  
3 and subject to the approval of the attorney general or other appropriate legal counsel of the  
4 member state represented by an Interstate Commission representative, shall defend such  
5 Interstate Commission representative in any civil action seeking to impose liability arising out of  
6 an actual or alleged act, error or omission that occurred within the scope of Interstate  
7 Commission employment, duties or responsibilities, or that the defendant had a reasonable basis  
8 for believing occurred within the scope of Interstate Commission employment, duties, or  
9 responsibilities, provided that the actual or alleged act, error, or omission did not result from  
10 intentional or willful and wanton misconduct on the part of such person.

11 (3) To the extent not covered by the state involved, member state, or the Interstate  
12 Commission, the representatives or employees of the Interstate Commission shall be held  
13 harmless in the amount of a settlement or judgment, including attorney's fees and costs, obtained  
14 against such persons arising out of an actual or alleged act, error, or omission that occurred  
15 within the scope of Interstate Commission employment, duties, or responsibilities, or that such  
16 persons had a reasonable basis for believing occurred within the scope of Interstate Commission  
17 employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission  
18 did not result from intentional or willful and wanton misconduct on the part of such persons.

19  
20 **SECTION 15. RULEMAKING FUNCTIONS OF THE INTERSTATE**  
21 **COMMISSION**

22 (a) The Interstate Commission shall promulgate reasonable rules in order to effectively  
23 and efficiently achieve the purposes of the Compact. Notwithstanding the foregoing, in the event

1 the Interstate Commission exercises its rulemaking authority in a manner that is beyond the  
2 scope of the purposes of the Compact, or the powers granted hereunder, then such an action by  
3 the Interstate Commission shall be invalid and have no force or effect.

4 (b) Rules deemed appropriate for the operations of the Interstate Commission shall be  
5 made pursuant to a rulemaking process that substantially conforms to the “Model State  
6 Administrative Procedure Act” of 2010, and subsequent amendments thereto.

7 (c) Not later than thirty (30) days after a rule is promulgated, any person may file a  
8 petition for judicial review of the rule in the United States District Court for the District of  
9 Columbia or the federal district where the Interstate Commission has its principal offices,  
10 provided that the filing of such a petition shall not stay or otherwise prevent the rule from  
11 becoming effective unless the court finds that the petitioner has a substantial likelihood of  
12 success. The court shall give deference to the actions of the Interstate Commission consistent  
13 with applicable law and shall not find the rule to be unlawful if the rule represents a reasonable  
14 exercise of the authority granted to the Interstate Commission.

15  
16 **SECTION 16. OVERSIGHT OF INTERSTATE COMPACT**

17 (a) The executive, legislative, and judicial branches of state government in each member  
18 state shall enforce the Compact and shall take all actions necessary and appropriate to effectuate  
19 the Compact’s purposes and intent. The provisions of the Compact and the rules promulgated  
20 hereunder shall have standing as statutory law but shall not override existing state authority to  
21 regulate the practice of medicine.

22 (b) All courts shall take judicial notice of the Compact and the rules in any judicial or  
23 administrative proceeding in a member state pertaining to the subject matter of the Compact  
24 which may affect the powers, responsibilities or actions of the Interstate Commission.

1 (c) The Interstate Commission shall be entitled to receive all service of process in any  
2 such proceeding, and shall have standing to intervene in the proceeding for all purposes. Failure  
3 to provide service of process to the Interstate Commission shall render a judgment or order void  
4 as to the Interstate Commission, the Compact, or promulgated rules.

5  
6 **SECTION 17. ENFORCEMENT OF INTERSTATE COMPACT**

7 (a) The Interstate Commission, in the reasonable exercise of its discretion, shall enforce  
8 the provisions and rules of the Compact.

9 (b) The Interstate Commission may, by majority vote of the Commissioners, initiate legal  
10 action in the United States District Court for the District of Columbia, or, at the discretion of the  
11 Interstate Commission, in the federal district where the Interstate Commission has its principal  
12 offices, to enforce compliance with the provisions of the Compact, and its promulgated rules and  
13 bylaws, against a member state in default. The relief sought may include both injunctive relief  
14 and damages. In the event judicial enforcement is necessary, the prevailing party shall be  
15 awarded all costs of such litigation including reasonable attorney's fees.

16 (c) The remedies herein shall not be the exclusive remedies of the Interstate Commission.  
17 The Interstate Commission may avail itself of any other remedies available under state law or the  
18 regulation of a profession.

19  
20 **SECTION 18. DEFAULT PROCEDURES**

21 (a) The grounds for default include, but are not limited to, failure of a member state to  
22 perform such obligations or responsibilities imposed upon it by the Compact, or the rules and  
23 bylaws of the Interstate Commission promulgated under the Compact.

1 (b) If the Interstate Commission determines that a member state has defaulted in the  
2 performance of its obligations or responsibilities under the Compact, or the bylaws or  
3 promulgated rules, the Interstate Commission shall:

4 (1) Provide written notice to the defaulting state and other member states, of the  
5 nature of the default, the means of curing the default, and any action taken by the Interstate  
6 Commission. The Interstate Commission shall specify the conditions by which the defaulting  
7 state must cure its default; and

8 (2) Provide remedial training and specific technical assistance regarding the  
9 default.

10 (c) If the defaulting state fails to cure the default, the defaulting state shall be terminated  
11 from the Compact upon an affirmative vote of a majority of the Commissioners and all rights,  
12 privileges, and benefits conferred by the Compact shall terminate on the effective date of  
13 termination. A cure of the default does not relieve the offending state of obligations or liabilities  
14 incurred during the period of the default.

15 (d) Termination of membership in the Compact shall be imposed only after all other  
16 means of securing compliance have been exhausted. Notice of intent to terminate shall be given  
17 by the Interstate Commission to the governor, the majority and minority leaders of the defaulting  
18 state's legislature, and each of the member states.

19 (e) The Interstate Commission shall establish rules and procedures to address licenses and  
20 physicians that are materially impacted by the termination of a member state, or the withdrawal  
21 of a member state.

22 (f) The member state which has been terminated is responsible for all dues, obligations,  
23 and liabilities incurred through the effective date of termination including obligations, the

1 performance of which extends beyond the effective date of termination.

2 (g) The Interstate Commission shall not bear any costs relating to any state that has been  
3 found to be in default or which has been terminated from the Compact, unless otherwise  
4 mutually agreed upon in writing between the Interstate Commission and the defaulting state.

5 (h) The defaulting state may appeal the action of the Interstate Commission by  
6 petitioning the United States District Court for the District of Columbia or the federal district  
7 where the Interstate Commission has its principal offices. The prevailing party shall be awarded  
8 all costs of such litigation including reasonable attorney's fees.

9  
10 **SECTION 19. DISPUTE RESOLUTION**

11 (a) The Interstate Commission shall attempt, upon the request of a member state, to  
12 resolve disputes which are subject to the Compact and which may arise among member states or  
13 member boards.

14 (b) The Interstate Commission shall promulgate rules providing for both mediation and  
15 binding dispute resolution as appropriate.

16  
17 **SECTION 20. MEMBER STATES, EFFECTIVE DATE AND AMENDMENT**

18 (a) Any state is eligible to become a member state of the Compact.

19 (b) The Compact shall become effective and binding upon legislative enactment of the  
20 Compact into law by no less than seven (7) states. Thereafter, it shall become effective and  
21 binding on a state upon enactment of the Compact into law by that state.

22 (c) The governors of non-member states, or their designees, shall be invited to participate  
23 in the activities of the Interstate Commission on a non-voting basis prior to adoption of the

1 Compact by all states.

2 (d) The Interstate Commission may propose amendments to the Compact for enactment  
3 by the member states. No amendment shall become effective and binding upon the Interstate  
4 Commission and the member states unless and until it is enacted into law by unanimous consent  
5 of the member states.

6

7 **SECTION 21. WITHDRAWAL**

8 (a) Once effective, the Compact shall continue in force and remain binding upon each  
9 and every member state; provided that a member state may withdraw from the Compact by  
10 specifically repealing the statute which enacted the Compact into law.

11 (b) Withdrawal from the Compact shall be by the enactment of a statute repealing the  
12 same, but shall not take effect until one (1) year after the effective date of such statute and until  
13 written notice of the withdrawal has been given by the withdrawing state to the governor of each  
14 other member state.

15 (c) The withdrawing state shall immediately notify the chairperson of the Interstate  
16 Commission in writing upon the introduction of legislation repealing the Compact in the  
17 withdrawing state.

18 (d) The Interstate Commission shall notify the other member states of the withdrawing  
19 state's intent to withdraw within sixty (60) days of its receipt of notice provided under subsection  
20 (c).

21 (e) The withdrawing state is responsible for all dues, obligations and liabilities incurred  
22 through the effective date of withdrawal, including obligations, the performance of which extend  
23 beyond the effective date of withdrawal.

1 (f) Reinstatement following withdrawal of a member state shall occur upon the  
2 withdrawing state reenacting the Compact or upon such later date as determined by the Interstate  
3 Commission.

4 (g) The Interstate Commission is authorized to develop rules to address the impact of the  
5 withdrawal of a member state on licenses granted in other member states to physicians who  
6 designated the withdrawing member state as the state of principal license.

7  
8 **SECTION 22. DISSOLUTION**

9 (a) The Compact shall dissolve effective upon the date of the withdrawal or default of the  
10 member state which reduces the membership in the Compact to one (1) member state.

11 (b) Upon the dissolution of the Compact, the Compact becomes null and void and shall  
12 be of no further force or effect, and the business and affairs of the Interstate Commission shall be  
13 concluded and surplus funds shall be distributed in accordance with the bylaws.

14  
15 **SECTION 23. SEVERABILITY AND CONSTRUCTION**

16 (a) The provisions of the Compact shall be severable, and if any phrase, clause, sentence,  
17 or provision is deemed unenforceable, the remaining provisions of the Compact shall be  
18 enforceable.

19 (b) The provisions of the Compact shall be liberally construed to effectuate its purposes.

20 (c) Nothing in the Compact shall be construed to prohibit the applicability of other  
21 interstate compacts to which the states are members.

22  
23 **SECTION 24. BINDING EFFECT OF COMPACT AND OTHER LAWS**

1           (a) Nothing herein prevents the enforcement of any other law of a member state that is  
2 not inconsistent with the Compact.

3           (b) All laws in a member state in conflict with the Compact are superseded to the extent of  
4 the conflict.

5           (c) All lawful actions of the Interstate Commission, including all rules and bylaws  
6 promulgated by the Commission, are binding upon the member states.

7           (d) All agreements between the Interstate Commission and the member states are binding  
8 in accordance with their terms.

9           (e) In the event any provision of the Compact exceeds the constitutional limits imposed  
10 on the legislature of any member state, such provision shall be ineffective to the extent of the  
11 conflict with the constitutional provision in question in that member state.



**DATE:** January 28, 2015

**TO:** Member Medical Board Executive Directors –  
Interstate Medical Licensure Compact Supporters

**FROM:** Humayun J. Chaudhry, DO, MACP  
FSMB President and CEO

**CC:** Don Polk, DO, FSMB Chair  
FSMB Board of Directors

**RE:** Interstate Medical Licensure Compact Misinformation

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The Federation of State Medical Boards (FSMB) has become aware in recent days of an effort being conducted by various individuals to undermine the Interstate Medical Licensure Compact.

This memorandum is being sent to the Executive Directors of those state medical and osteopathic boards that have formally endorsed or supported the Compact. It lists the concerns of those opposed to the Compact and refutes each of the misrepresentations and falsehoods that we have heard. Please feel free to share these with your state board members, state legislators and state medical and osteopathic societies, as appropriate.

As you know, the Compact was put together by representatives of several state boards and has been endorsed by physician organizations such as the American Medical Association (AMA) and by 25 state medical and osteopathic boards in just the few short months since it was introduced. It provides a reasonable, innovative way to get more physicians licensed in the states where their services are vitally needed – while preserving all of the protections of state-based medical regulation and allowing physicians the freedom to choose the licensing path that works best for them. The Compact has already been introduced in 10 state legislatures (Iowa, Minnesota, Nebraska, Oklahoma, South Dakota, Texas, Utah, Vermont, West Virginia, and Wyoming).

There have been false and misleading public statements and distortions made about the Compact in an effort to discredit it and help thwart its adoption by state legislatures. Ironically, such an effort empowers those that favor a national approach to medical licensure.

The anti-Compact campaign is riddled with falsehoods that are easily debunked by simply reading the model legislation that was crafted in an open and collaborative fashion by the state medical boards with input from stakeholders across the nation. Perhaps the most egregious of these falsehoods is the notion that the Compact would somehow force practicing physicians to participate in additional levels of medical certification beyond basic licensing and standard requirements for continuing medical education (CME).

Participation in the proposed Compact is totally optional, and is intended only for those physicians who wish to practice in multiple states and who want to avoid the process of applying for multiple state licenses one at a time. It in no way changes the requirements for state medical licensure for physicians seeking one license within a state or for those who choose to become licensed in multiple states through existing processes. The status quo remains, for any physician who wants to continue to use current licensing processes.

The FSMB has prepared a fact sheet about “Six Myths About the Compact”, outlined below, that refutes the misleading claims.. The fact sheet will also soon be available at the FSMB’s Interstate Medical Licensure Compact website ([www.licenseportability.org](http://www.licenseportability.org)).

### **SIX MYTHS ABOUT THE INTERSTATE MEDICAL LICENSURE COMPACT**

*MYTH: It is alleged that the definition of a physician in the Compact is at variance with the definition of a physician by all other state medical boards.*

**FACT:** The definition of a physician in the Interstate Compact relates only to the eligibility to receive a license through the process outlined in the Compact. The Compact definition does not change the existing definition of a physician in a state’s existing Medical Practice Act, nor does it change the basic requirements for state medical licensure of a physician seeking only one license within a state or who chooses to become licensed in additional states through existing processes.

**FACT:** In order for the Compact to be acceptable in ALL states, the definition of a physician was drafted by state medical boards in a manner that meets the highest standards already required for expedited licensure or licensure by endorsement (many states already have standards in place for expedited licensure or licensure by endorsement that require specialty-board certification.)

**FACT:** Physicians who do not meet the requirements, including those not specialty certified, are still eligible to apply for state medical licensure in a member state through the current process. Initial estimates show that up to 80% of licensed physicians in the U.S. are currently eligible to participate in the Compact, if they choose to do so.

*MYTH: It is alleged that physicians participating in the Compact would be required to participate in Maintenance of Certification (MOC), or that MOC is an eligibility requirement for the Compact.*

**FACT:** The Compact makes absolutely no reference to Maintenance of Certification (MOC) or its osteopathic counterpart, Osteopathic Continuous Certification (OCC). The Compact does not require a physician to participate in MOC, nor does it require or even make mention of the need to participate in MOC as a licensure renewal requirement in any state. Once a physician is issued a license via the Compact from a state, he or she must adhere (as now) to the renewal and continuing medical education requirements of that state. No state requires MOC as a condition for licensure renewal, and therefore, this will not be required for physicians participating in the Compact.

*MYTH: It is claimed that the Compact would "supersede a state's authority and control over the practice of medicine."*

**FACT:** The Compact reflects the effort of the state medical boards to develop a dynamic, self-regulatory system of expedited state medical licensure over which the participating states maintain control through a coordinated legislative and administrative process. Coordination through a compact is not the same as commandeering state authority. It is the ultimate expression of state authority.

**FACT:** Some of the groups that are distorting the facts about the Compact are contradicting their own policies and goals: The American Legislative Exchange Council (ALEC), for example, which is now criticizing the Compact, has supported interstate compacts as solutions to other multi-state-based legislative challenges in the past.

*MYTH: It is claimed that the Compact would change a state's Medical Practice Act.*

**FACT:** The Compact clearly states that it would not change a state's Medical Practice Act. From the Compact's preamble: "The Compact creates another pathway for licensure and does not otherwise change a state's existing Medical Practice Act."

**FACT:** The Compact also adopts the prevailing standard for state medical licensure found in the Medical Practice Acts of each state, affirming that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter.

*MYTH: It is asserted that it would be expensive for a state to extricate itself from the Interstate Medical Licensure Compact.*

**FACT:** State participation in the Compact is, and will remain, voluntary. States are free to withdraw from the Compact and may do so by repealing the enacted statute. The withdrawal provisions of the Interstate Compact are consistent with interstate compacts currently enacted throughout the country.

*MYTH: It is claimed that the Compact represents a regulatory excess, and costs and burdens on the state will be increased.*

**FACT:** The process of licensure proposed in the Compact would reduce costs, streamlining the process for licensees. Rather than having to obtain individual documents for multiple states, which is both expensive and time consuming, member states can rely on verified, shared information to speed the licensee through the licensing process. Licensees would have to pay the fees set by their state in order to obtain and maintain a license via the Compact, just as with licenses currently obtained via current methods. The Compact is not an example of regulatory excess but an example of regulatory common sense.

For more information about the Compact, visit [www.licenseportability.org](http://www.licenseportability.org).

**About the Federation of State Medical Boards:** The Federation of State Medical Boards (FSMB) is a national non-profit organization representing all medical boards within the United States and its territories that license and discipline allopathic and osteopathic physicians and, in some jurisdictions, other health care professionals. FSMB leads by promoting excellence in medical practice, licensure and regulation as the national resource and voice on behalf of state medical boards in their protection of the public. To learn more about FSMB visit: <http://www.fsmb.org/>. You can also follow FSMB on Twitter (@theFSMB and @FSMBPolicy) and Facebook by liking the Federation of State Medical Boards page.

**INTERSTATE MEDICAL LICENSURE COMPACT**



1 **INTERSTATE MEDICAL LICENSURE COMPACT**

2 **SECTION 1. PURPOSE**

3 In order to strengthen access to health care, and in recognition of the advances in the delivery of  
4 health care, the member states of the Interstate Medical Licensure Compact have allied in  
5 common purpose to develop a comprehensive process that complements the existing licensing  
6 and regulatory authority of state medical boards, provides a streamlined process that allows  
7 physicians to become licensed in multiple states, thereby enhancing the portability of a medical  
8 license and ensuring the safety of patients. The Compact creates another pathway for licensure  
9 and does not otherwise change a state's existing Medical Practice Act. The Compact also adopts  
10 the prevailing standard for licensure and affirms that the practice of medicine occurs where the  
11 patient is located at the time of the physician-patient encounter, and therefore, requires the  
12 physician to be under the jurisdiction of the state medical board where the patient is located.  
13 State medical boards that participate in the Compact retain the jurisdiction to impose an adverse  
14 action against a license to practice medicine in that state issued to a physician through the  
15 procedures in the Compact.

16  
17 **SECTION 2. DEFINITIONS**

18 In this compact:

19 (a) "Bylaws" means those bylaws established by the Interstate Commission pursuant to  
20 Section 11 for its governance, or for directing and controlling its actions and conduct.

21 (b) "Commissioner" means the voting representative appointed by each member board  
22 pursuant to Section 11.

23 (c) "Conviction" means a finding by a court that an individual is guilty of a criminal  
24 offense through adjudication, or entry of a plea of guilt or no contest to the charge by the

1 offender. Evidence of an entry of a conviction of a criminal offense by the court shall be  
2 considered final for purposes of disciplinary action by a member board.

3 (d) "Expedited License" means a full and unrestricted medical license granted by a  
4 member state to an eligible physician through the process set forth in the Compact.

5 (e) "Interstate Commission" means the interstate commission created pursuant to Section  
6 11.

7 (f) "License" means authorization by a state for a physician to engage in the practice of  
8 medicine, which would be unlawful without the authorization.

9 (g) "Medical Practice Act" means laws and regulations governing the practice of  
10 allopathic and osteopathic medicine within a member state.

11 (h) "Member Board" means a state agency in a member state that acts in the sovereign  
12 interests of the state by protecting the public through licensure, regulation, and education of  
13 physicians as directed by the state government.

14 (i) "Member State" means a state that has enacted the Compact.

15 (j) "Practice of Medicine" means the clinical prevention, diagnosis, or treatment of  
16 human disease, injury, or condition requiring a physician to obtain and maintain a license in  
17 compliance with the Medical Practice Act of a member state.

18 (k) "Physician" means any person who:

19 (1) Is a graduate of a medical school accredited by the Liaison Committee on  
20 Medical Education, the Commission on Osteopathic College Accreditation, or a medical school  
21 listed in the International Medical Education Directory or its equivalent;

22 (2) Passed each component of the United States Medical Licensing Examination  
23 (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA)

1 within three attempts, or any of its predecessor examinations accepted by a state medical board  
2 as an equivalent examination for licensure purposes;

3 (3) Successfully completed graduate medical education approved by the  
4 Accreditation Council for Graduate Medical Education or the American Osteopathic  
5 Association;

6 (4) Holds specialty certification or a time-unlimited specialty certificate recognized  
7 by the American Board of Medical Specialties or the American Osteopathic Association's  
8 Bureau of Osteopathic Specialists;

9 (5) Possesses a full and unrestricted license to engage in the practice of medicine  
10 issued by a member board;

11 (6) Has never been convicted, received adjudication, deferred adjudication,  
12 community supervision, or deferred disposition for any offense by a court of appropriate  
13 jurisdiction;

14 (7) Has never held a license authorizing the practice of medicine subjected to  
15 discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action  
16 related to non-payment of fees related to a license;

17 (8) Has never had a controlled substance license or permit suspended or revoked by  
18 a state or the United States Drug Enforcement Administration; and

19 (9) Is not under active investigation by a licensing agency or law enforcement  
20 authority in any state, federal, or foreign jurisdiction.

21 (l) "Offense" means a felony, gross misdemeanor, or crime of moral turpitude.

22 (m) "Rule" means a written statement by the Interstate Commission promulgated  
23 pursuant to Section 12 of the Compact that is of general applicability, implements, interprets, or

1 prescribes a policy or provision of the Compact, or an organizational, procedural, or practice  
2 requirement of the Interstate Commission, and has the force and effect of statutory law in a  
3 member state, and includes the amendment, repeal, or suspension of an existing rule.

4 (n) "State" means any state, commonwealth, district, or territory of the United States.

5 (o) "State of Principal License" means a member state where a physician holds a license  
6 to practice medicine and which has been designated as such by the physician for purposes of  
7 registration and participation in the Compact.

## 8 **No definition of disciplinary action!**

### 9 **SECTION 3. ELIGIBILITY**

10 (a) A physician must meet the eligibility requirements as defined in Section 2(k) to  
11 receive an expedited license under the terms and provisions of the Compact.

12 (b) A physician who does not meet the requirements of Section 2(k) may obtain a license  
13 to practice medicine in a member state if the individual complies with all laws and requirements,  
14 other than the Compact, relating to the issuance of a license to practice medicine in that state.

### 15 16 **SECTION 4. DESIGNATION OF STATE OF PRINCIPAL LICENSE**

17 (a) A physician shall designate a member state as the state of principal license for  
18 purposes of registration for expedited licensure through the Compact if the physician possesses a  
19 full and unrestricted license to practice medicine in that state, and the state is:

20 (1) the state of primary residence for the physician, or

21 (2) the state where at least 25% of the practice of medicine occurs, or

22 (3) the location of the physician's employer, or

23 (4) if no state qualifies under subsection (1), subsection (2), or subsection (3), the

1 state designated as state of residence for purpose of federal income tax.

2 (b) A physician may redesignate a member state as state of principal license at any time,  
3 as long as the state meets the requirements in subsection (a).

4 (c) The Interstate Commission is authorized to develop rules to facilitate redesignation of  
5 another member state as the state of principal license.

6

## 7 SECTION 5. APPLICATION AND ISSUANCE OF EXPEDITED LICENSURE

8 (a) A physician seeking licensure through the Compact shall file an application for an  
9 expedited license with the member board of the state selected by the physician as the state of  
10 principal license.

11 (b) Upon receipt of an application for an expedited license, the member board within the  
12 state selected as the state of principal license shall evaluate whether the physician is eligible for  
13 expedited licensure and issue a letter of qualification, verifying or denying the physician's  
14 eligibility, to the Interstate Commission.

**Why here? This paragraph indicates that a graduate member state does not have to primarily verify if principal licensure state has already done so. However, this section applies to primary state.**

19 **NEW** (ii) The member board within the state selected as the state of principal license  
20 shall, in the course of verifying eligibility, perform a criminal background check of an applicant,  
21 including the use of the results of fingerprint or other biometric data checks compliant with the  
22 requirements of the Federal Bureau of Investigation, with the exception of federal employees who  
23 have suitability determination in accordance with U.S. C.F.R. §731.202.

24 (iii) Appeal on the determination of eligibility shall be made to the member state

1 where the application was filed and shall be subject to the law of that state.

2 (c) Upon verification in subsection (b), physicians eligible for an expedited license shall

3 complete the registration process established by the Interstate Commission to receive a license in  
4 a member state selected pursuant to subsection (a), including the payment of any applicable  
5 fees.

**(c) complete registration and pay fees in principal state.**



**payment of**

6 (d) After receiving verification of eligibility under subsection (b) and any fees under

7 subsection (c), a member board shall issue an expedited license to the physician. This license

8 shall authorize the physician to practice medicine in the issuing state consistent with the Medical

9 Practice Act and all applicable laws and regulations of the issuing member board and member

10 state. **principal state or other member state?**

11 (e) An expedited license shall be valid for a period consistent with the licensure period in

12 the member state and in the same manner as required for other physicians holding a full and

13 unrestricted license within the member state.

14 (f) An expedited license obtained through the Compact shall be terminated if a physician

15 fails to maintain a license in the state of principal licensure for a non-disciplinary reason, without

16 redesignation of a new **new class of license required?**

17 (g) The Interstate Commission is authorized to develop rules regarding the application

18 process, including payment of any applicable fees, and the issuance of an expedited license.



19 **no right of review by member states?**

## 20 SECTION 6. FEES FOR EXPEDITED LICENSURE

21 (a) A member state issuing an expedited license authorizing the practice of medicine in

22 that state may impose a fee for a license issued or renewed through the Compact.

23 (b) The Interstate Commission is authorized to develop rules regarding fees for expedited

## binding on the states?

1 licenses.

2

### 3 SECTION 7. RENEWAL AND CONTINUED PARTICIPATION

4 (a) A physician seeking to renew an expedited license granted in a member state shall  
5 complete a renewal process with the Interstate Commission if the physician:

6 (1) Maintains a full and unrestricted license in a state of principal license;

7 (2) Has not been convicted, received adjudication, deferred adjudication,  
8 community supervision, or deferred disposition for any offense by a court of appropriate  
9 jurisdiction;

10 (3) Has not had a license authorizing the practice of medicine subject to discipline  
11 by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to  
12 non-payment of fees related to a license; and

13 (4) Has not had a controlled substance license or permit suspended or revoked by  
14 a state or the United States Drug Enforcement Administration.

15 (b) Physicians shall comply with all continuing professional development or continuing  
16 medical education requirements for renewal of a license issued by a member state.

17 (c) The Interstate Commission shall collect any renewal fees charged for the renewal of  
18 a license and distribute the fees to the applicable member board. any % kept by IC?

19 (d) Upon receipt of any renewal fees collected in subsection (c), a member board shall  
20 renew the physician's license. before receipt by state?

21 (e) Physician information collected by the Interstate Commission during the renewal  
22 process will be distributed to all member boards.

23 (f) The Interstate Commission is authorized to develop rules to address renewal of

1 licenses obtained through the Compact.

2  
3 **SECTION 8. COORDINATED INFORMATION SYSTEM**  
4

5 (a) The Interstate Commission shall establish a database of all physicians licensed, or  
6 who have applied for licensure, under Section 5. **who funds?**

7 (b) Notwithstanding any other provision of law, member boards shall report to the  
8 Interstate Commission any public action or complaints against a licensed physician who has  
9 applied or received an expedited license through the Compact. **do we need to**

10 (c) Member boards shall report disciplinary or investigatory information, if necessary,  
11 necessary and proper by rule of the Interstate Commission. **define by rule**

12 (d) Member boards may report any non-public complaint, **public vs. non-**  
13 information not required by subsection (c) to the Interstate Commission. **public complaint?**

14 (e) Member boards shall share complaint or disciplinary information about a physician  
15 upon request of another member board.

16 (f) All information provided to the Interstate Commission or distributed by member  
17 boards shall be confidential, filed under seal, and used only for investigatory or disciplinary  
18 matters.

19 (g) The Interstate Commission is authorized to develop rules for mandated or  
20 discretionary sharing of information by member boards. **without state**  
21 **comment?**

22 **SECTION 9. JOINT INVESTIGATIONS**

23 (a) Licensure and disciplinary records of physicians are deemed investigative.

24 (b) In addition to the authority granted to a member board by its respective Medical  
25 Practice Act or other applicable state law, a member board may participate with other member

1 boards in joint investigations of physicians licensed by the member boards.

2 (c) A subpoena issued by a member state shall be enforceable in other member states.

3 (d) Member boards may share any investigative, litigation, or compliance materials in  
4 furtherance of any joint or individual investigation initiated under the Compact.

5 (e) Any member state may investigate actual or alleged violations of the statutes  
6 authorizing the practice of medicine in any other member state in which a physician holds a  
7 license to practice medicine.

**applies to std licenses as well?**

9 **SECTION 10. DISCIPLINARY ACTIONS**

10 (a) Any disciplinary action taken by any member board against a physician licensed  
11 through the Compact shall be deemed unprofessional conduct which may be subject to discipline  
12 by other member boards, in addition to any violation of the Medical Practice Act or regulations  
13 in that state. **Need to tightly define disciplinary**

14 (b) If a license granted to a physician by the member board in the state of principal  
15 license is revoked, surrendered or relinquished in lieu of discipline, or suspended, then all  
16 licenses issued to the physician by member boards shall automatically be placed, without further  
17 action necessary by any member board, on the same status. If the member board in the state of  
18 principal license subsequently reinstates the physician's license, a license issued to the  
19 physician by any other member board shall remain encumbered until that respective member  
20 board takes action to reinstate the license in a manner consistent with the Medical Practice Act of  
21 that state.

22 (c) If disciplinary action is taken against a physician by a member board not in the state  
23 of principal license, any other member board may deem the action conclusive as to matter of law

**(c) and (d) apply to Non-principal state actions**

**disciplinary action by non-primary state does not automatically create like action in other expedited states**

1 and fact decided, and:

- 2 (i) impose sanctions consistent with the Medical Practice Act of that state;
- 3
- 4 (ii) or pursue separate disciplinary action against the physician under its
- 5 respective Medical Practice Act, regardless of the action taken in other member states.

6 (d) If a license granted to a physician by a member board is revoked, surrendered or  
7 relinquished in lieu of discipline, or suspended, then any license(s) issued to the physician by any  
8 other member board(s) shall be suspended, automatically and immediately without further action  
9 necessary by the other member board(s), for ninety (90) days upon entry of the order by the  
10 disciplining board, to permit the member board(s) to investigate the basis for the action under the  
11 Medical Practice Act of that state. A member board may terminate the automatic suspension of  
12 the license it issued prior to the completion of the ninety (90) day suspension period in a manner  
13 consistent with the Medical Practice Act of that state.

**do we have the wherewithal to evaluate actions by another state within 90 days?**

**SECTION 11. INTERSTATE MEDICAL LICENSURE COMPACT**

**COMMISSION**

- 17 (a) The member states hereby create the "Interstate Medical Licensure Compact
- 18 Commission".
- 19 (b) The purpose of the Interstate Commission is the administration of the Interstate
- 20 Medical Licensure Compact, which is a discretionary state function.
- 21 (c) The Interstate Commission shall be a body corporate and joint agency of the member
- 22 states and shall have all the responsibilities, powers, and duties set forth in the Compact, and
- 23 such additional powers as may be conferred upon it by a subsequent concurrent action of the

1 respective legislatures of the member states in accordance with the terms of the Compact.

2 (d) The Interstate Commission shall consist of two voting representatives appointed by  
3 each member state who shall serve as Commissioners. In states where allopathic and osteopathic  
4 physicians are regulated by separate member boards, or if the licensing and disciplinary authority  
5 is split between multiple member boards within a member state, the member state shall appoint  
6 one representative from each member board. A Commissioner shall be a(n):

7 (1) Allopathic or osteopathic physician appointed to a member board;

8 (2) Executive director, executive secretary, or similar executive of a member  
9 board; or

10 (3) Member of the public appointed to a member board.

11 (e) The Interstate Commission shall meet at least once each calendar year. A portion of  
12 this meeting shall be a business meeting to address such matters as may properly come before the  
13 Commission, including the election of officers. The chairperson may call additional meetings  
14 and shall call for a meeting upon the request of a majority of the member states.

15 (f) The bylaws may provide for meetings of the Interstate Commission to be conducted  
16 by telecommunication or electronic communication.

17 (g) Each Commissioner participating at a meeting of the Interstate Commission is entitled  
18 to one vote. A majority of Commissioners shall constitute a quorum for the transaction of  
19 business, unless a larger quorum is required by the bylaws of the Interstate Commission. A  
20 Commissioner shall not delegate a vote to another Commissioner. In the absence of its  
21 Commissioner, a member state may delegate voting authority for a specified meeting to another  
22 person from that state who shall meet the requirements of subsection (d).

23 (h) The Interstate Commission shall provide public notice of all meetings and all

1 meetings shall be open to the public. The Interstate Commission may close a meeting, in full or  
2 in portion, where it determines by a two-thirds vote of the Commissioners present that an open  
3 meeting would be likely to:

4 (1) Relate solely to the internal personnel practices and procedures of the  
5 Interstate Commission;

6 (2) Discuss matters specifically exempted from disclosure by federal statute;

7 (3) Discuss trade secrets, commercial, or financial information that is privileged  
8 or confidential;

9 (4) Involve accusing a person of a crime, or formally censuring a person;

10 (5) Discuss information of a personal nature where disclosure would constitute a  
11 clearly unwarranted invasion of personal privacy;

12 (6) Discuss investigative records compiled for law enforcement purposes; or

13 (7) Specifically relate to the participation in a civil action or other legal  
14 proceeding.

15 (i) The Interstate Commission shall keep minutes which shall fully describe all matters  
16 discussed in a meeting and shall provide a full and accurate summary of actions taken, including  
17 record of any roll call votes.

18 (j) The Interstate Commission shall make its information and official records, to the  
19 extent not otherwise designated in the Compact or by its rules, available to the public for  
20 inspection.

21 (k) The Interstate Commission shall establish an executive committee, which shall  
22 include officers, members, and others as determined by the bylaws. The executive committee  
23 shall have the power to act on behalf of the Interstate Commission, with the exception of

1 rulemaking, during periods when the Interstate Commission is not in session. When acting on  
2 behalf of the Interstate Commission, the executive committee shall oversee the administration of  
3 the Compact including enforcement and compliance with the provisions of the Compact, its  
4 bylaws and rules, and other such duties as necessary.

5 (l) The Interstate Commission may establish other committees for governance and  
6 administration of the Compact.

7

## 8 **SECTION 12. POWERS AND DUTIES OF THE INTERSTATE COMMISSION**

9 The Interstate Commission shall have the duty and power to:

10 (a) Oversee and maintain the administration of the Compact;

11 (b) Promulgate rules which shall be binding to the extent and in the manner provided for  
12 in the Compact;

13 (c) Issue, upon the request of a member state or member board, advisory opinions  
14 concerning the meaning or interpretation of the Compact, its bylaws, rules, and actions;

15 (d) Enforce compliance with Compact provisions, the rules promulgated by the Interstate  
16 Commission, and the bylaws, using all necessary and proper means, including but not limited to  
17 the use of judicial process; **Funding?**

18 (e) Establish and appoint committees including, but not limited to, an executive  
19 committee as required by Section 11, which shall have the power to act on behalf of the  
20 Interstate Commission in carrying out its powers and duties;

21 (f) Pay, or provide for the payment of the expenses related to the establishment,  
22 organization, and ongoing activities of the Interstate Commission;

23 (g) Establish and maintain one or more offices;

24 (h) Borrow, accept, hire, or contract for services of personnel;

- 1 (i) Purchase and maintain insurance and bonds;
- 2 (j) Employ an executive director who shall have such powers to employ, select or appoint  
3 employees, agents, or consultants, and to determine their qualifications, define their duties, and  
4 fix their compensation;
- 5 (k) Establish personnel policies and programs relating to conflicts of interest, rates of  
6 compensation, and qualifications of personnel;
- 7 (l) Accept donations and grants of money, equipment, supplies, materials and services,  
8 and to receive, utilize, and dispose of it in a manner consistent with the conflict of interest  
9 policies established by the Interstate Commission;
- 10 (m) Lease, purchase, accept contributions or donations of, or otherwise to own, hold,  
11 improve or use, any property, real, personal, or mixed;
- 12 (n) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any  
13 property, real, personal, or mixed;
- 14 (o) Establish a budget and make expenditures;
- 15 (p) Adopt a seal and bylaws governing the management and operation of the Interstate  
16 Commission;
- 17 (q) Report annually to the legislatures and governors of the member states concerning the  
18 activities of the Interstate Commission during the preceding year. Such reports shall also include  
19 reports of financial audits and any recommendations that may have been adopted by the  
20 Interstate Commission;
- 21 (r) Coordinate education, training, and public awareness regarding the Compact, its  
22 implementation, and its operation;
- 23 (s) Maintain records in accordance with the bylaws;

1 (t) Seek and obtain trademarks, copyrights, and patents; and

2 (u) Perform such functions as may be necessary or appropriate to achieve the purposes of  
3 the Compact.

4  
5 **SECTION 13. FINANCE POWERS** **blank check for states**

6 (a) The Interstate Commission may levy on and collect an annual assessment from each  
7 member state to cover the cost of the operations and activities of the Interstate Commission and  
8 its staff. The total assessment must be sufficient to cover the annual budget approved each year  
9 for which revenue is not provided by other sources. The aggregate annual assessment amount  
10 shall be allocated upon a formula to be determined by the Interstate Commission, which shall  
11 promulgate a rule binding upon all member states.

12 (b) The Interstate Commission shall not incur obligations of any kind prior to securing  
13 the funds adequate to meet the same.

14 (c) The Interstate Commission shall not pledge the credit of any of the member states,  
15 except by, and with the authority of, the member state.

16 (d) The Interstate Commission shall be subject to a yearly financial audit conducted by a  
17 certified or licensed public accountant and the report of the audit shall be included in the annual  
18 report of the Interstate Commission.

19  
20 **SECTION 14. ORGANIZATION AND OPERATION OF THE INTERSTATE**  
21 **COMMISSION**

22 (a) The Interstate Commission shall, by a majority of Commissioners present and voting,  
23 adopt bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes

1 of the Compact within twelve (12) months of the first Interstate Commission meeting.

2 (b) The Interstate Commission shall elect or appoint annually from among its  
3 Commissioners a chairperson, a vice-chairperson, and a treasurer, each of whom shall have such  
4 authority and duties as may be specified in the bylaws. The chairperson, or in the chairperson's  
5 absence or disability, the vice-chairperson, shall preside at all meetings of the Interstate  
6 Commission.

7 (c) Officers selected in subsection (b) shall serve without remuneration from the  
8 Interstate Commission.

9 (d) The officers and employees of the Interstate Commission shall be immune from suit  
10 and liability, either personally or in their official capacity, for a claim for damage to or loss of  
11 property or personal injury or other civil liability caused or arising out of, or relating to, an actual  
12 or alleged act, error, or omission that occurred, or that such person had a reasonable basis for  
13 believing occurred, within the scope of Interstate Commission employment, duties, or  
14 responsibilities; provided that such person shall not be protected from suit or liability for  
15 damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of  
16 such person.

17 (1) The liability of the executive director and employees of the Interstate  
18 Commission or representatives of the Interstate Commission, acting within the scope of such  
19 person's employment or duties for acts, errors, or omissions occurring within such person's state,  
20 may not exceed the limits of liability set forth under the constitution and laws of that state for  
21 state officials, employees, and agents. The Interstate Commission is considered to be an  
22 instrumentality of the states for the purposes of any such action. Nothing in this subsection shall  
23 be construed to protect such person from suit or liability for damage, loss, injury, or liability

1 caused by the intentional or willful and wanton misconduct of such person.

2 (2) The Interstate Commission shall defend the executive director, its employees,  
3 and subject to the approval of the attorney general or other appropriate legal counsel of the  
4 member state represented by an Interstate Commission representative, shall defend such  
5 Interstate Commission representative in any civil action seeking to impose liability arising out of  
6 an actual or alleged act, error or omission that occurred within the scope of Interstate  
7 Commission employment, duties or responsibilities, or that the defendant had a reasonable basis  
8 for believing occurred within the scope of Interstate Commission employment, duties, or  
9 responsibilities, provided that the actual or alleged act, error, or omission did not result from  
10 intentional or willful and wanton misconduct on the part of such person.

11 (3) To the extent not covered by the state involved, member state, or the Interstate  
12 Commission, the representatives or employees of the Interstate Commission shall be held  
13 harmless in the amount of a settlement or judgment, including attorney's fees and costs, obtained  
14 against such persons arising out of an actual or alleged act, error, or omission that occurred  
15 within the scope of Interstate Commission employment, duties, or responsibilities, or that such  
16 persons had a reasonable basis for believing occurred within the scope of Interstate Commission  
17 employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission  
18 did not result from intentional or willful and wanton misconduct on the part of such persons.

19  
20 **SECTION 15. RULEMAKING FUNCTIONS OF THE INTERSTATE**  
21 **COMMISSION**

22 (a) The Interstate Commission shall promulgate reasonable rules in order to effectively  
23 and efficiently achieve the purposes of the Compact. Notwithstanding the foregoing, in the event

1 the Interstate Commission exercises its rulemaking authority in a manner that is beyond the  
2 scope of the purposes of the Compact, or the powers granted hereunder, then such an action by  
3 the Interstate Commission shall be invalid and have no force or effect.

4 (b) Rules deemed appropriate for the operations of the Interstate Commission shall be  
5 made pursuant to a rulemaking process that substantially conforms to the “Model State  
6 Administrative Procedure Act” of 2010, and subsequent amendments thereto.

7 (c) Not later than thirty (30) days after a rule is promulgated, any person may file a  
8 petition for judicial review of the rule in the United States District Court for the District of  
9 Columbia or the federal district where the Interstate Commission has its principal offices,  
10 provided that the filing of such a petition shall not stay or otherwise prevent the rule from  
11 becoming effective unless the court finds that the petitioner has a substantial likelihood of  
12 success. The court shall give deference to the actions of the Interstate Commission consistent  
13 with applicable law and shall not find the rule to be unlawful if the rule represents a reasonable  
14 exercise of the authority granted to the Interstate Commission.

15  
16 **SECTION 16. OVERSIGHT OF INTERSTATE COMPACT**

17 (a) The executive, legislative, and judicial branches of state government in each member  
18 state shall enforce the Compact and shall take all actions necessary and appropriate to effectuate  
19 the Compact’s purposes and intent. The provisions of the Compact and the rules promulgated  
20 hereunder shall have standing as statutory law but shall not override existing state authority to  
21 regulate the practice of medicine.

22 (b) All courts shall take judicial notice of the Compact and the rules in any judicial or  
23 administrative proceeding in a member state pertaining to the subject matter of the Compact  
24 which may affect the powers, responsibilities or actions of the Interstate Commission.

1 (c) The Interstate Commission shall be entitled to receive all service of process in any  
2 such proceeding, and shall have standing to intervene in the proceeding for all purposes. Failure  
3 to provide service of process to the Interstate Commission shall render a judgment or order void  
4 as to the Interstate Commission, the Compact, or promulgated rules.

5  
6 **SECTION 17. ENFORCEMENT OF INTERSTATE COMPACT**

7 (a) The Interstate Commission, in the reasonable exercise of its discretion, shall enforce  
8 the provisions and rules of the Compact.

9 (b) The Interstate Commission may, by majority vote of the Commissioners, initiate legal  
10 action in the United States District Court for the District of Columbia, or, at the discretion of the  
11 Interstate Commission, in the federal district where the Interstate Commission has its principal  
12 offices, to enforce compliance with the provisions of the Compact, and its promulgated rules and  
13 bylaws, against a member state in default. The relief sought may include both injunctive relief  
14 and damages. In the event judicial enforcement is necessary, the prevailing party shall be  
15 awarded all costs of such litigation including reasonable attorney's fees.

16 (c) The remedies herein shall not be the exclusive remedies of the Interstate Commission.  
17 The Interstate Commission may avail itself of any other remedies available under state law or the  
18 regulation of a profession.

19  
20 **SECTION 18. DEFAULT PROCEDURES**

21 (a) The grounds for default include, but are not limited to, failure of a member state to  
22 perform such obligations or responsibilities imposed upon it by the Compact, or the rules and  
23 bylaws of the Interstate Commission promulgated under the Compact.

1 (b) If the Interstate Commission determines that a member state has defaulted in the  
2 performance of its obligations or responsibilities under the Compact, or the bylaws or  
3 promulgated rules, the Interstate Commission shall:

4 (1) Provide written notice to the defaulting state and other member states, of the  
5 nature of the default, the means of curing the default, and any action taken by the Interstate  
6 Commission. The Interstate Commission shall specify the conditions by which the defaulting  
7 state must cure its default; and

8 (2) Provide remedial training and specific technical assistance regarding the  
9 default.

10 (c) If the defaulting state fails to cure the default, the defaulting state shall be terminated  
11 from the Compact upon an affirmative vote of a majority of the Commissioners and all rights,  
12 privileges, and benefits conferred by the Compact shall terminate on the effective date of  
13 termination. A cure of the default does not relieve the offending state of obligations or liabilities  
14 incurred during the period of the default.

15 (d) Termination of membership in the Compact shall be imposed only after all other  
16 means of securing compliance have been exhausted. Notice of intent to terminate shall be given  
17 by the Interstate Commission to the governor, the majority and minority leaders of the defaulting  
18 state's legislature, and each of the member states.

19 (e) The Interstate Commission shall establish rules and procedures to address licenses and  
20 physicians that are materially impacted by the termination of a member state, or the withdrawal  
21 of a member state.

22 (f) The member state which has been terminated is responsible for all dues, obligations,  
23 and liabilities incurred through the effective date of termination including obligations, the

1 performance of which extends beyond the effective date of termination.

2 (g) The Interstate Commission shall not bear any costs relating to any state that has been  
3 found to be in default or which has been terminated from the Compact, unless otherwise  
4 mutually agreed upon in writing between the Interstate Commission and the defaulting state.

5 (h) The defaulting state may appeal the action of the Interstate Commission by  
6 petitioning the United States District Court for the District of Columbia or the federal district  
7 where the Interstate Commission has its principal offices. The prevailing party shall be awarded  
8 all costs of such litigation including reasonable attorney's fees.

9  
10 **SECTION 19. DISPUTE RESOLUTION**

11 (a) The Interstate Commission shall attempt, upon the request of a member state, to  
12 resolve disputes which are subject to the Compact and which may arise among member states or  
13 member boards.

14 (b) The Interstate Commission shall promulgate rules providing for both mediation and  
15 binding dispute resolution as appropriate.

16  
17 **SECTION 20. MEMBER STATES, EFFECTIVE DATE AND AMENDMENT**

18 (a) Any state is eligible to become a member state of the Compact.

19 (b) The Compact shall become effective and binding upon legislative enactment of the  
20 Compact into law by no less than seven (7) states. Thereafter, it shall become effective and  
21 binding on a state upon enactment of the Compact into law by that state.

22 (c) The governors of non-member states, or their designees, shall be invited to participate  
23 in the activities of the Interstate Commission on a non-voting basis prior to adoption of the

1 Compact by all states.

2 (d) The Interstate Commission may propose amendments to the Compact for enactment  
3 by the member states. No amendment shall become effective and binding upon the Interstate  
4 Commission and the member states unless and until it is enacted into law by unanimous consent  
5 of the member states.

6

7 **SECTION 21. WITHDRAWAL**

8 (a) Once effective, the Compact shall continue in force and remain binding upon each  
9 and every member state; provided that a member state may withdraw from the Compact by  
10 specifically repealing the statute which enacted the Compact into law.

11 (b) Withdrawal from the Compact shall be by the enactment of a statute repealing the  
12 same, but shall not take effect until one (1) year after the effective date of such statute and until  
13 written notice of the withdrawal has been given by the withdrawing state to the governor of each  
14 other member state.

15 (c) The withdrawing state shall immediately notify the chairperson of the Interstate  
16 Commission in writing upon the introduction of legislation repealing the Compact in the  
17 withdrawing state.

18 (d) The Interstate Commission shall notify the other member states of the withdrawing  
19 state's intent to withdraw within sixty (60) days of its receipt of notice provided under subsection  
20 (c).

21 (e) The withdrawing state is responsible for all dues, obligations and liabilities incurred  
22 through the effective date of withdrawal, including obligations, the performance of which extend  
23 beyond the effective date of withdrawal.

1 (f) Reinstatement following withdrawal of a member state shall occur upon the  
2 withdrawing state reenacting the Compact or upon such later date as determined by the Interstate  
3 Commission.

4 (g) The Interstate Commission is authorized to develop rules to address the impact of the  
5 withdrawal of a member state on licenses granted in other member states to physicians who  
6 designated the withdrawing member state as the state of principal license.

7  
8 **SECTION 22. DISSOLUTION**

9 (a) The Compact shall dissolve effective upon the date of the withdrawal or default of the  
10 member state which reduces the membership in the Compact to one (1) member state.

11 (b) Upon the dissolution of the Compact, the Compact becomes null and void and shall  
12 be of no further force or effect, and the business and affairs of the Interstate Commission shall be  
13 concluded and surplus funds shall be distributed in accordance with the bylaws.

14  
15 **SECTION 23. SEVERABILITY AND CONSTRUCTION**

16 (a) The provisions of the Compact shall be severable, and if any phrase, clause, sentence,  
17 or provision is deemed unenforceable, the remaining provisions of the Compact shall be  
18 enforceable.

19 (b) The provisions of the Compact shall be liberally construed to effectuate its purposes.

20 (c) Nothing in the Compact shall be construed to prohibit the applicability of other  
21 interstate compacts to which the states are members.

22  
23 **SECTION 24. BINDING EFFECT OF COMPACT AND OTHER LAWS**

1 (a) Nothing herein prevents the enforcement of any other law of a member state that is  
2 not inconsistent with the Compact.

3 (b) All laws in a member state in conflict with the Compact are superseded to the extent of  
4 the conflict.

5 (c) All lawful actions of the Interstate Commission, including all rules and bylaws  
6 promulgated by the Commission, are binding upon the member states.

7 (d) All agreements between the Interstate Commission and the member states are binding  
8 in accordance with their terms.

9 (e) In the event any provision of the Compact exceeds the constitutional limits imposed  
10 on the legislature of any member state, such provision shall be ineffective to the extent of the  
11 conflict with the constitutional provision in question in that member state.

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

|  |   |   |  |
|--|---|---|--|
| 1) Name and Title of Person Submitting the Request:<br><br>Taylor Thompson, Bureau Assistant<br>on behalf of<br>Tom Ryan, Executive Director   |   | 2) Date When Request Submitted:<br><br>2/27/15<br>Items will be considered late if submitted after 12:00 p.m. on the deadline date:<br>▪ 8 business days before the meeting |  |
| 3) Name of Board, Committee, Council, Sections:<br><br>Medical Examining Board   |   |   |  |
| 4) Meeting Date:<br><br>3/18/15  | 5) Attachments:<br><input checked="" type="checkbox"/> Yes<br><input type="checkbox"/> No   | 6) How should the item be titled on the agenda page?<br><br>FSMB Matters:<br>Annual Meeting Resolutions   |  |
| 7) Place Item in:<br><input checked="" type="checkbox"/> Open Session<br><input type="checkbox"/> Closed Session<br><input type="checkbox"/> Both  | 8) Is an appearance before the Board being scheduled?<br><br><input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> )<br><input checked="" type="checkbox"/> No | 9) Name of Case Advisor(s), if required:  |  |
| 10) Describe the issue and action that should be addressed:  |   |   |  |
| 11) Authorization  |   |   |  |
| <b>Taylor Thompson</b>   |   | <b>2/27/15</b>  |  |
| Signature of person making this request  |   | Date  |  |
| Supervisor (if required)   |   | Date  |  |
| Executive Director signature (indicates approval to add post agenda deadline item to agenda)    Date   |   |   |  |
| Directions for including supporting documents:<br>1. This form should be attached to any documents submitted to the agenda.<br>2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director.<br>3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting. |   |   |  |

Federation of State Medical Boards  
House of Delegates Meeting  
April 25, 2015

Subject: Consistency in the Format of EMR to Enhance Readability and Usability  
Introduced by: Texas Medical Board  
Approved: November 2014

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**Whereas,** Studies, published in the journal *Health Affairs*, found that in 2013, almost 78% of office-based physicians reported they adopted some type of EMR system.

**Whereas,** Government incentives to switch to EMR have resulted in many physicians having adopted EMR systems that produce an abundance of data that obscure the original purpose of the Medical Record to chronicle and enhance the health care of individual patients provided by medical professionals; and

**Whereas,** Much of the important information, including a patient's medications, habits, past surgeries and health problems, family history, social history, notes to about important issues, patient/family names, is scattered in different places in the EMR and can easily be overlooked or missed. Identifying important health information in the EMR in a manner that alerts medical professionals will enhance patient care; and

**Whereas,** EMR systems generally require collection of data as separate encounters and they lack tools to provide physicians with the longitudinal clinical view of this mass of data to get a complete picture of the patient, except those with only the simplest of problems; and

**Whereas,** Given the current varying system capabilities of EMR systems being utilized by healthcare professionals, the lack of conformity of documentation styles and the varying state requirements, creating and enforcing a rule that requires a specifically delineated patient care summary or chart to be part of every EMR medical record would be difficult to implement and enforce; and

**Whereas,** There are no general guidelines or suggestions for practitioners for standardizing the consistency or uniformity in their EMR systems;

Therefore, be it hereby

**Resolved;** That the Federation of State Medical Boards create a committee to consider recommended guidelines on electronic medical records that will provide an understandable, longitudinal, patient centric, view of EMR data that will allow medical professionals to care for individual patients over time and for Medical Boards to oversee the process.

**Federation of State Medical Boards  
House of Delegates Meeting  
April 25, 2015**

Subject: Revision of FSMB Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain

Introduced by: Washington State Medical Quality Assurance Commission

Approved: January 2015

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**Whereas,** The FSMB adopted a Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain in 2013; and

**Whereas,** Recent studies have provided important new information on the use of opioids for pain, necessitating a revision to the Model Policy to make it aligned with the current science, as follows:

1. New studies do not support a “no ceiling on dose” principle. Language in the Model Policy suggesting otherwise should be removed:
  - a. “Physicians will not be sanctioned solely for prescribing opioid analgesics or the does (mg/mcg) prescribed for legitimate medical purposes.”
  - b. “The Board will judge the validity of the physician’s treatment of a patient on the basis of available documentation, rather than solely on the quantity and duration of medication administered.”
2. A recent study by the Agency for Healthcare Quality and Research finds a lack of long-term data on the effectiveness of opioids for chronic pain.
3. Recent studies demonstrate the impact of escalating doses, the relationship of higher doses with overdose events, and that escalating doses do not have an impact on improving health outcomes.
4. A study published in the New England Journal of Medicine in January 2015 found a national decrease in abuse of prescription opioid medications between 2011 and 2013 and called for further changes in public health policy.
5. The Model Policy should be expanded to address how opioids are used for acute and subacute pain episodes to prevent chronic use that is not evidence based. There is new evidence that the use of opioids in the acute and subacute pain period may be associated with adverse impact, particularly on the initiation and potentiation of disability, particularly in working-age people.

6. The Model Policy emphasizes the importance of co-morbid substance abuse and mental health disorders, but needs stronger warnings on the increased risk of overdoses and addiction. This is particularly true for the synergistic effect of respiratory depression regarding concomitant use of benzodiazepines and sedative-hypnotics. For example, benzodiazepines were involved in 31% of opioid analgesic poisoning deaths in 2011.
7. The Model Policy needs greater guidance and specificity on tapering opioids. New data suggest that opioids are frequently continued in patients who have experienced an overdose event, and these patients may experience a subsequent overdose event or death.
8. The Model Policy should give more attention to addiction. Current evidence suggests that addiction may be more common than previously appreciated. In addition, the current definitions of substance abuse disorder may be very different for persons prescribed opioids for chronic pain than it is for street users.
9. The Centers for Disease Control and Prevention will be producing updated guidelines for opioid use in 2015. This guidance should be included in the updated FSBM Model Policy.
10. In 2014, the latest edition of Safe and Responsible Opioid Prescribing, by Dr. Scott Fishman was issued. The Model Policy should reflect the latest guidance for safe and effective opioid prescribing provided by Dr. Fishman (2014 edition).
11. Language in the Model Policy is not consistent with language in at least six state medical boards who have revised their policies or rules in the last two years.

Therefore, be it hereby

**Resolved:** That the Federation of State Medical Boards will establish a work group to review the current science and revise the Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain.

**Federation of State Medical Boards  
House of Delegates Meeting  
April 25, 2015**

Subject: Developing Model Language in Board Actions and Coordinating with ABMS on the Effects of Board Actions on Specialty Board Certification

Introduced by: Washington State Medical Quality Assurance Commission

Approved: January 2015

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*Whereas,* State medical boards are responsible for protecting the citizens of their states by ensuring that physicians are qualified and competent; and

*Whereas,* State medical boards are in the best position to determine the appropriate action necessary to protect the public under the facts of each case; and

*Whereas,* State medical boards are in the best position to determine if a physician can practice with reasonable skill and safety while under the monitoring of a state medical board; and

*Whereas,* State medical board action can result in the loss of specialty board certification, significantly impacting a physician's ability to practice and reducing access to care; and

*Whereas,* State medical boards do not have a good understanding of what types of board actions or language will result in the loss of specialty board certification, creating uncertainty in imposing discipline and affecting decision-making; and

*Whereas,* There are two reasons for the uncertainty:  
(1) Specialty boards do not have consistent standards to determine whether state medical board action should result in a loss of board certification, and (2) state medical boards do not use consistent language in its board actions; and

*Whereas,* The American Board of Medical Specialties is currently working on a consistency project to develop standard terminology in all aspects of its business, one of which is the evaluation of state medical board actions;

*Whereas,* State medical boards will benefit from undertaking a similar project to develop consistent language in its board actions;

**Whereas,** Having consistent terminology and coordination between ABMS boards and state medical boards will help state medical boards better understand what types of action will affect a physician's board certification status, improve decision-making, promote consistent outcomes, and better protect the public;

Therefore, be it hereby

**Resolved:** That the Federation of State Medical Boards will establish a work group to develop model language in board actions and to coordinate with the American Board of Medical Specialties to better understand the types of actions and language that will affect board certification and to promote consistent outcomes among the state medical boards and the ABMS.

**Federation of State Medical Boards  
House of Delegates Meeting  
April 25, 2015**

Subject: Task Force to Study Access by Regulatory Boards to Electronic Medical Records

Introduced by: Minnesota Board of Medical Practice

Approved: January 2015

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**Whereas,** An increasing number of health care systems and individual providers maintain patient medical records in an electronic format; and

**Whereas,** Regulatory boards require access to patient medical records as part of investigative and enforcement processes; and

**Whereas,** Completeness and coherence of a medical record produced from an electronic format may be inconsistent;

Therefore, be it hereby

**Resolved,** That the Federation of State Medical Boards (FSMB) will establish a task force to review the format of an electronic medical record; and be it further

**Resolved,** That the FSMB task force will evaluate how information is entered into an electronic record and how information is compiled and released from an electronic format; and be it further

**Resolved,** That the FSMB task force will evaluate the feasibility of regulatory boards being allowed direct access to electronic medical records for the purpose of reviewing and downloading information necessary to a board process.

**Federation of State Medical Boards  
House of Delegates Meeting  
April 25, 2015**

Subject: Best Practices in the Use of Social Media by Medical and Osteopathic Boards

Introduced by: North Carolina Medical Board

Approved: February 2015

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**Whereas,** The North Carolina Medical Board (the “NCMB”) is committed to disseminating information to its constituents, which include the public, Board licensees, the media and others. Outreach and transparency are key features of the Strategic Plan which the Board adopted in 2014; and

**Whereas,** The NCMB uses different forms of social media to communicate news and information, including public disciplinary actions taken by the NCMB, and has noted the rapid growth in the use of social media by government and other public agencies; and

**Whereas,** Posting on social media has augmented the NCMB’s more traditional forms of communicating, which include printed and online publications and RSS feeds; and

**Whereas,** Concerns have been raised about the use of social media to communicate public disciplinary actions taken by the NCMB; some characterize social media as an informal and inappropriate means of such communication that undermines the integrity of the NCMB’s disciplinary process; and

**Whereas,** During its January meeting, the NCMB had a vigorous debate on the appropriate use of social media. On one hand, the NCMB’s work should be transparent and its communications should be effective and modern. On the other hand, the NCMB should be fair to licensees and should communicate about licensees with respect and decorum.

Therefore, be it hereby

**Resolved,** That at its 2016 Annual Meeting, the Federation of State Medical Boards shall present information on current uses of social media by regulatory agencies and recommend guidelines on best practices for regulatory agencies to follow in using social media and other forms of communication to publicize Board news and information, including public disciplinary actions.

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

|  |   |  |  |
|--|---|--|--|
| 1) Name and Title of Person Submitting the Request:<br><br>Taylor Thompson, Bureau Assistant<br>on behalf of<br>Tom Ryan, Executive Director   |   | 2) Date When Request Submitted:<br><br>3/6/15<br>Items will be considered late if submitted after 12:00 p.m. on the deadline date:<br>▪ 8 business days before the meeting         |  |
| 3) Name of Board, Committee, Council, Sections:<br><br>Medical Examining Board   |   |  |  |
| 4) Meeting Date:<br><br>3/18/15  | 5) Attachments:<br><input type="checkbox"/> Yes<br><input checked="" type="checkbox"/> No   | 6) How should the item be titled on the agenda page?<br><br>National Governors Association's Policy Academy on Reducing Prescription Drug Abuse - Report from Dr. Timothy Westlake |  |
| 7) Place Item in:<br><input checked="" type="checkbox"/> Open Session<br><input type="checkbox"/> Closed Session<br><input type="checkbox"/> Both  | 8) Is an appearance before the Board being scheduled?<br><br><input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> )<br><input checked="" type="checkbox"/> No | 9) Name of Case Advisor(s), if required:   |  |
| 10) Describe the issue and action that should be addressed:  |   |  |  |
| 11) Authorization  |   |  |  |
| <b>Taylor Thompson</b>   |   | <b>3/6/15</b>  |  |
| Signature of person making this request  |   | Date   |  |
| Supervisor (if required)   |   | Date   |  |
| Executive Director signature (indicates approval to add post agenda deadline item to agenda)    Date   |   |  |  |
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**State of Wisconsin  
Department of Safety & Professional Services**

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| 7) Place Item in:<br><input checked="" type="checkbox"/> Open Session<br><input type="checkbox"/> Closed Session<br><input type="checkbox"/> Both  | 8) Is an appearance before the Board being scheduled?<br><br><input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> )<br><input checked="" type="checkbox"/> No | 9) Name of Case Advisor(s), if required:   |  |
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## Syllabus

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States v. Detroit Timber & Lumber Co.*, 200 U. S. 321, 337.

**SUPREME COURT OF THE UNITED STATES**

## Syllabus

**NORTH CAROLINA STATE BOARD OF DENTAL  
EXAMINERS v. FEDERAL TRADE COMMISSION****CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR  
THE FOURTH CIRCUIT**

No. 13–534. Argued October 14, 2014—Decided February 25, 2015

North Carolina’s Dental Practice Act (Act) provides that the North Carolina State Board of Dental Examiners (Board) is “the agency of the State for the regulation of the practice of dentistry.” The Board’s principal duty is to create, administer, and enforce a licensing system for dentists; and six of its eight members must be licensed, practicing dentists.

The Act does not specify that teeth whitening is “the practice of dentistry.” Nonetheless, after dentists complained to the Board that nondentists were charging lower prices for such services than dentists did, the Board issued at least 47 official cease-and-desist letters to nondentist teeth whitening service providers and product manufacturers, often warning that the unlicensed practice of dentistry is a crime. This and other related Board actions led nondentists to cease offering teeth whitening services in North Carolina.

The Federal Trade Commission (FTC) filed an administrative complaint, alleging that the Board’s concerted action to exclude nondentists from the market for teeth whitening services in North Carolina constituted an anticompetitive and unfair method of competition under the Federal Trade Commission Act. An Administrative Law Judge (ALJ) denied the Board’s motion to dismiss on the ground of state-action immunity. The FTC sustained that ruling, reasoning that even if the Board had acted pursuant to a clearly articulated state policy to displace competition, the Board must be actively supervised by the State to claim immunity, which it was not. After a hearing on the merits, the ALJ determined that the Board had unreasonably restrained trade in violation of antitrust law. The FTC again sustained the ALJ, and the Fourth Circuit affirmed the FTC in

## Syllabus

all respects.

*Held:* Because a controlling number of the Board’s decisionmakers are active market participants in the occupation the Board regulates, the Board can invoke state-action antitrust immunity only if it was subject to active supervision by the State, and here that requirement is not met. Pp. 5–18.

(a) Federal antitrust law is a central safeguard for the Nation’s free market structures. However, requiring States to conform to the mandates of the Sherman Act at the expense of other values a State may deem fundamental would impose an impermissible burden on the States’ power to regulate. Therefore, beginning with *Parker v. Brown*, 317 U. S. 341, this Court interpreted the antitrust laws to confer immunity on the anticompetitive conduct of States acting in their sovereign capacity. Pp. 5–6.

(b) The Board’s actions are not cloaked with *Parker* immunity. A nonsovereign actor controlled by active market participants—such as the Board—enjoys *Parker* immunity only if “‘the challenged restraint . . . [is] clearly articulated and affirmatively expressed as state policy,’ and . . . ‘the policy . . . [is] actively supervised by the State.’” *FTC v. Phoebe Putney Health System, Inc.*, 568 U. S. \_\_\_, \_\_\_ (quoting *California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc.*, 445 U. S. 97, 105). Here, the Board did not receive active supervision of its anticompetitive conduct. Pp. 6–17.

(1) An entity may not invoke *Parker* immunity unless its actions are an exercise of the State’s sovereign power. See *Columbia v. Omni Outdoor Advertising, Inc.*, 499 U. S. 365, 374. Thus, where a State delegates control over a market to a nonsovereign actor the Sherman Act confers immunity only if the State accepts political accountability for the anticompetitive conduct it permits and controls. Limits on state-action immunity are most essential when a State seeks to delegate its regulatory power to active market participants, for dual allegiances are not always apparent to an actor and prohibitions against anticompetitive self-regulation by active market participants are an axiom of federal antitrust policy. Accordingly, *Parker* immunity requires that the anticompetitive conduct of nonsovereign actors, especially those authorized by the State to regulate their own profession, result from procedures that suffice to make it the State’s own. *Midcal*’s two-part test provides a proper analytical framework to resolve the ultimate question whether an anticompetitive policy is indeed the policy of a State. The first requirement—clear articulation—rarely will achieve that goal by itself, for entities purporting to act under state authority might diverge from the State’s considered definition of the public good and engage in private self-dealing. The second *Midcal* requirement—active supervision—seeks to avoid this

## Syllabus

harm by requiring the State to review and approve interstitial policies made by the entity claiming immunity. Pp. 6–10.

(2) There are instances in which an actor can be excused from *Midcal's* active supervision requirement. Municipalities, which are electorally accountable, have general regulatory powers, and have no private price-fixing agenda, are subject exclusively to the clear articulation requirement. See *Hallie v. Eau Claire*, 471 U. S. 34, 35. That *Hallie* excused municipalities from *Midcal's* supervision rule for these reasons, however, all but confirms the rule's applicability to actors controlled by active market participants. Further, in light of *Omni's* holding that an otherwise immune entity will not lose immunity based on ad hoc and *ex post* questioning of its motives for making particular decisions, 499 U. S., at 374, it is all the more necessary to ensure the conditions for granting immunity are met in the first place, see *FTC v. Ticor Title Ins. Co.*, 504 U. S. 621, 633, and *Phoebe Putney, supra*, at \_\_\_\_\_. The clear lesson of precedent is that *Midcal's* active supervision test is an essential prerequisite of *Parker* immunity for any nonsovereign entity—public or private—controlled by active market participants. Pp. 10–12.

(3) The Board's argument that entities designated by the States as agencies are exempt from *Midcal's* second requirement cannot be reconciled with the Court's repeated conclusion that the need for supervision turns not on the formal designation given by States to regulators but on the risk that active market participants will pursue private interests in restraining trade. State agencies controlled by active market participants pose the very risk of self-dealing *Midcal's* supervision requirement was created to address. See *Goldfarb v. Virginia State Bar*, 421 U. S. 773, 791. This conclusion does not question the good faith of state officers but rather is an assessment of the structural risk of market participants' confusing their own interests with the State's policy goals. While *Hallie* stated "it is likely that active state supervision would also not be required" for agencies, 471 U. S., at 46, n. 10, the entity there was more like prototypical state agencies, not specialized boards dominated by active market participants. The latter are similar to private trade associations vested by States with regulatory authority, which must satisfy *Midcal's* active supervision standard. 445 U. S., at 105–106. The similarities between agencies controlled by active market participants and such associations are not eliminated simply because the former are given a formal designation by the State, vested with a measure of government power, and required to follow some procedural rules. See *Hallie, supra*, at 39. When a State empowers a group of active market participants to decide who can participate in its market, and on what terms, the need for supervision is manifest. Thus,

## Syllabus

the Court holds today that a state board on which a controlling number of decisionmakers are active market participants in the occupation the board regulates must satisfy *Midcal's* active supervision requirement in order to invoke state-action antitrust immunity. Pp. 12–14.

(4) The State argues that allowing this FTC order to stand will discourage dedicated citizens from serving on state agencies that regulate their own occupation. But this holding is not inconsistent with the idea that those who pursue a calling must embrace ethical standards that derive from a duty separate from the dictates of the State. Further, this case does not offer occasion to address the question whether agency officials, including board members, may, under some circumstances, enjoy immunity from damages liability. Of course, States may provide for the defense and indemnification of agency members in the event of litigation, and they can also ensure *Parker* immunity is available by adopting clear policies to displace competition and providing active supervision. Arguments against the wisdom of applying the antitrust laws to professional regulation absent compliance with the prerequisites for invoking *Parker* immunity must be rejected, see *Patrick v. Burget*, 486 U. S. 94, 105–106, particularly in light of the risks licensing boards dominated by market participants may pose to the free market. Pp. 14–16.

(5) The Board does not contend in this Court that its anticompetitive conduct was actively supervised by the State or that it should receive *Parker* immunity on that basis. The Act delegates control over the practice of dentistry to the Board, but says nothing about teeth whitening. In acting to expel the dentists' competitors from the market, the Board relied on cease-and-desist letters threatening criminal liability, instead of other powers at its disposal that would have invoked oversight by a politically accountable official. Whether or not the Board exceeded its powers under North Carolina law, there is no evidence of any decision by the State to initiate or concur with the Board's actions against the nondentists. P. 17.

(c) Here, where there are no specific supervisory systems to be reviewed, it suffices to note that the inquiry regarding active supervision is flexible and context-dependent. The question is whether the State's review mechanisms provide "realistic assurance" that a non-sovereign actor's anticompetitive conduct "promotes state policy, rather than merely the party's individual interests." *Patrick*, 486 U. S., 100–101. The Court has identified only a few constant requirements of active supervision: The supervisor must review the substance of the anticompetitive decision, see *id.*, at 102–103; the supervisor must have the power to veto or modify particular decisions to ensure they accord with state policy, see *ibid.*; and the "mere potential for state

Syllabus

supervision is not an adequate substitute for a decision by the State,” *Ticor, supra*, at 638. Further, the state supervisor may not itself be an active market participant. In general, however, the adequacy of supervision otherwise will depend on all the circumstances of a case. Pp. 17–18.

717 F. 3d 359, affirmed.

KENNEDY, J., delivered the opinion of the Court, in which ROBERTS, C. J., and GINSBURG, BREYER, SOTOMAYOR, and KAGAN, JJ., joined. ALITO, J., filed a dissenting opinion, in which SCALIA and THOMAS, JJ., joined.

Opinion of the Court

NOTICE: This opinion is subject to formal revision before publication in the preliminary print of the United States Reports. Readers are requested to notify the Reporter of Decisions, Supreme Court of the United States, Washington, D. C. 20543, of any typographical or other formal errors, in order that corrections may be made before the preliminary print goes to press.

**SUPREME COURT OF THE UNITED STATES**

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No. 13–534

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**NORTH CAROLINA STATE BOARD OF DENTAL  
EXAMINERS, PETITIONER *v.* FEDERAL  
TRADE COMMISSION**

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF  
APPEALS FOR THE FOURTH CIRCUIT

[February 25, 2015]

JUSTICE KENNEDY delivered the opinion of the Court.

This case arises from an antitrust challenge to the actions of a state regulatory board. A majority of the board’s members are engaged in the active practice of the profession it regulates. The question is whether the board’s actions are protected from Sherman Act regulation under the doctrine of state-action antitrust immunity, as defined and applied in this Court’s decisions beginning with *Parker v. Brown*, 317 U. S. 341 (1943).

I  
A

In its Dental Practice Act (Act), North Carolina has declared the practice of dentistry to be a matter of public concern requiring regulation. N. C. Gen. Stat. Ann. §90–22(a) (2013). Under the Act, the North Carolina State Board of Dental Examiners (Board) is “the agency of the State for the regulation of the practice of dentistry.” §90–22(b).

The Board’s principal duty is to create, administer, and enforce a licensing system for dentists. See §§90–29 to

90–41. To perform that function it has broad authority over licensees. See §90–41. The Board’s authority with respect to unlicensed persons, however, is more restricted: like “any resident citizen,” the Board may file suit to “perpetually enjoin any person from . . . unlawfully practicing dentistry.” §90–40.1.

The Act provides that six of the Board’s eight members must be licensed dentists engaged in the active practice of dentistry. §90–22. They are elected by other licensed dentists in North Carolina, who cast their ballots in elections conducted by the Board. *Ibid.* The seventh member must be a licensed and practicing dental hygienist, and he or she is elected by other licensed hygienists. *Ibid.* The final member is referred to by the Act as a “consumer” and is appointed by the Governor. *Ibid.* All members serve 3-year terms, and no person may serve more than two consecutive terms. *Ibid.* The Act does not create any mechanism for the removal of an elected member of the Board by a public official. See *ibid.*

Board members swear an oath of office, §138A–22(a), and the Board must comply with the State’s Administrative Procedure Act, §150B–1 *et seq.*, Public Records Act, §132–1 *et seq.*, and open-meetings law, §143–318.9 *et seq.* The Board may promulgate rules and regulations governing the practice of dentistry within the State, provided those mandates are not inconsistent with the Act and are approved by the North Carolina Rules Review Commission, whose members are appointed by the state legislature. See §§90–48, 143B–30.1, 150B–21.9(a).

## B

In the 1990’s, dentists in North Carolina started whitening teeth. Many of those who did so, including 8 of the Board’s 10 members during the period at issue in this case, earned substantial fees for that service. By 2003, nondentists arrived on the scene. They charged lower

## Opinion of the Court

prices for their services than the dentists did. Dentists soon began to complain to the Board about their new competitors. Few complaints warned of possible harm to consumers. Most expressed a principal concern with the low prices charged by nondentists.

Responding to these filings, the Board opened an investigation into nondentist teeth whitening. A dentist member was placed in charge of the inquiry. Neither the Board's hygienist member nor its consumer member participated in this undertaking. The Board's chief operations officer remarked that the Board was "going forth to do battle" with nondentists. App. to Pet. for Cert. 103a. The Board's concern did not result in a formal rule or regulation reviewable by the independent Rules Review Commission, even though the Act does not, by its terms, specify that teeth whitening is "the practice of dentistry."

Starting in 2006, the Board issued at least 47 cease-and-desist letters on its official letterhead to nondentist teeth whitening service providers and product manufacturers. Many of those letters directed the recipient to cease "all activity constituting the practice of dentistry"; warned that the unlicensed practice of dentistry is a crime; and strongly implied (or expressly stated) that teeth whitening constitutes "the practice of dentistry." App. 13, 15. In early 2007, the Board persuaded the North Carolina Board of Cosmetic Art Examiners to warn cosmetologists against providing teeth whitening services. Later that year, the Board sent letters to mall operators, stating that kiosk teeth whiteners were violating the Dental Practice Act and advising that the malls consider expelling violators from their premises.

These actions had the intended result. Nondentists ceased offering teeth whitening services in North Carolina.

## C

In 2010, the Federal Trade Commission (FTC) filed an

administrative complaint charging the Board with violating §5 of the Federal Trade Commission Act, 38 Stat. 719, as amended, 15 U. S. C. §45. The FTC alleged that the Board's concerted action to exclude nondentists from the market for teeth whitening services in North Carolina constituted an anticompetitive and unfair method of competition. The Board moved to dismiss, alleging state-action immunity. An Administrative Law Judge (ALJ) denied the motion. On appeal, the FTC sustained the ALJ's ruling. It reasoned that, even assuming the Board had acted pursuant to a clearly articulated state policy to displace competition, the Board is a "public/private hybrid" that must be actively supervised by the State to claim immunity. App. to Pet. for Cert. 49a. The FTC further concluded the Board could not make that showing.

Following other proceedings not relevant here, the ALJ conducted a hearing on the merits and determined the Board had unreasonably restrained trade in violation of antitrust law. On appeal, the FTC again sustained the ALJ. The FTC rejected the Board's public safety justification, noting, *inter alia*, "a wealth of evidence . . . suggesting that non-dentist provided teeth whitening is a safe cosmetic procedure." *Id.*, at 123a.

The FTC ordered the Board to stop sending the cease-and-desist letters or other communications that stated nondentists may not offer teeth whitening services and products. It further ordered the Board to issue notices to all earlier recipients of the Board's cease-and-desist orders advising them of the Board's proper sphere of authority and saying, among other options, that the notice recipients had a right to seek declaratory rulings in state court.

On petition for review, the Court of Appeals for the Fourth Circuit affirmed the FTC in all respects. 717 F. 3d 359, 370 (2013). This Court granted certiorari. 571 U. S. \_\_\_ (2014).

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## II

Federal antitrust law is a central safeguard for the Nation’s free market structures. In this regard it is “as important to the preservation of economic freedom and our free-enterprise system as the Bill of Rights is to the protection of our fundamental personal freedoms.” *United States v. Topco Associates, Inc.*, 405 U. S. 596, 610 (1972). The antitrust laws declare a considered and decisive prohibition by the Federal Government of cartels, price fixing, and other combinations or practices that undermine the free market.

The Sherman Act, 26 Stat. 209, as amended, 15 U. S. C. §1 *et seq.*, serves to promote robust competition, which in turn empowers the States and provides their citizens with opportunities to pursue their own and the public’s welfare. See *FTC v. Ticor Title Ins. Co.*, 504 U. S. 621, 632 (1992). The States, however, when acting in their respective realm, need not adhere in all contexts to a model of unfettered competition. While “the States regulate their economies in many ways not inconsistent with the antitrust laws,” *id.*, at 635–636, in some spheres they impose restrictions on occupations, confer exclusive or shared rights to dominate a market, or otherwise limit competition to achieve public objectives. If every duly enacted state law or policy were required to conform to the mandates of the Sherman Act, thus promoting competition at the expense of other values a State may deem fundamental, federal antitrust law would impose an impermissible burden on the States’ power to regulate. See *Exxon Corp. v. Governor of Maryland*, 437 U. S. 117, 133 (1978); see also Easterbrook, *Antitrust and the Economics of Federalism*, 26 J. Law & Econ. 23, 24 (1983).

For these reasons, the Court in *Parker v. Brown* interpreted the antitrust laws to confer immunity on anticompetitive conduct by the States when acting in their sovereign capacity. See 317 U. S., at 350–351. That ruling

recognized Congress' purpose to respect the federal balance and to "embody in the Sherman Act the federalism principle that the States possess a significant measure of sovereignty under our Constitution." *Community Communications Co. v. Boulder*, 455 U. S. 40, 53 (1982). Since 1943, the Court has reaffirmed the importance of *Parker's* central holding. See, e.g., *Ticor, supra*, at 632–637; *Hoover v. Ronwin*, 466 U. S. 558, 568 (1984); *Lafayette v. Louisiana Power & Light Co.*, 435 U. S. 389, 394–400 (1978).

### III

In this case the Board argues its members were invested by North Carolina with the power of the State and that, as a result, the Board's actions are cloaked with *Parker* immunity. This argument fails, however. A nonsovereign actor controlled by active market participants—such as the Board—enjoys *Parker* immunity only if it satisfies two requirements: "first that 'the challenged restraint . . . be one clearly articulated and affirmatively expressed as state policy,' and second that 'the policy . . . be actively supervised by the State.'" *FTC v. Phoebe Putney Health System, Inc.*, 568 U. S. \_\_\_, \_\_\_ (2013) (slip op., at 7) (quoting *California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc.*, 445 U. S. 97, 105 (1980)). The parties have assumed that the clear articulation requirement is satisfied, and we do the same. While North Carolina prohibits the unauthorized practice of dentistry, however, its Act is silent on whether that broad prohibition covers teeth whitening. Here, the Board did not receive active supervision by the State when it interpreted the Act as addressing teeth whitening and when it enforced that policy by issuing cease-and-desist letters to nondentist teeth whiteners.

### A

Although state-action immunity exists to avoid conflicts

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between state sovereignty and the Nation’s commitment to a policy of robust competition, *Parker* immunity is not unbounded. “[G]iven the fundamental national values of free enterprise and economic competition that are embodied in the federal antitrust laws, ‘state action immunity is disfavored, much as are repeals by implication.’” *Phoebe Putney, supra*, at \_\_\_\_ (slip op., at 7) (quoting *Ticor, supra*, at 636).

An entity may not invoke *Parker* immunity unless the actions in question are an exercise of the State’s sovereign power. See *Columbia v. Omni Outdoor Advertising, Inc.*, 499 U. S. 365, 374 (1991). State legislation and “decision[s] of a state supreme court, acting legislatively rather than judicially,” will satisfy this standard, and “*ipso facto* are exempt from the operation of the antitrust laws” because they are an undoubted exercise of state sovereign authority. *Hoover, supra*, at 567–568.

But while the Sherman Act confers immunity on the States’ own anticompetitive policies out of respect for federalism, it does not always confer immunity where, as here, a State delegates control over a market to a non-sovereign actor. See *Parker, supra*, at 351 (“[A] state does not give immunity to those who violate the Sherman Act by authorizing them to violate it, or by declaring that their action is lawful”). For purposes of *Parker*, a nonsovereign actor is one whose conduct does not automatically qualify as that of the sovereign State itself. See *Hoover, supra*, at 567–568. State agencies are not simply by their governmental character sovereign actors for purposes of state-action immunity. See *Goldfarb v. Virginia State Bar*, 421 U. S. 773, 791 (1975) (“The fact that the State Bar is a state agency for some limited purposes does not create an antitrust shield that allows it to foster anticompetitive practices for the benefit of its members”). Immunity for state agencies, therefore, requires more than a mere facade of state involvement, for it is necessary in light of

*Parker's* rationale to ensure the States accept political accountability for anticompetitive conduct they permit and control. See *Ticor*, 504 U. S., at 636.

Limits on state-action immunity are most essential when the State seeks to delegate its regulatory power to active market participants, for established ethical standards may blend with private anticompetitive motives in a way difficult even for market participants to discern. Dual allegiances are not always apparent to an actor. In consequence, active market participants cannot be allowed to regulate their own markets free from antitrust accountability. See *Midcal*, *supra*, at 106 (“The national policy in favor of competition cannot be thwarted by casting [a] gauzy cloak of state involvement over what is essentially a private price-fixing arrangement”). Indeed, prohibitions against anticompetitive self-regulation by active market participants are an axiom of federal antitrust policy. See, e.g., *Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U. S. 492, 501 (1988); *Hoover*, *supra*, at 584 (Stevens, J., dissenting) (“The risk that private regulation of market entry, prices, or output may be designed to confer monopoly profits on members of an industry at the expense of the consuming public has been the central concern of . . . our antitrust jurisprudence”); see also Elhauge, *The Scope of Antitrust Process*, 104 Harv. L. Rev. 667, 672 (1991). So it follows that, under *Parker* and the Supremacy Clause, the States’ greater power to attain an end does not include the lesser power to negate the congressional judgment embodied in the Sherman Act through unsupervised delegations to active market participants. See Garland, *Antitrust and State Action: Economic Efficiency and the Political Process*, 96 Yale L. J. 486, 500 (1986).

*Parker* immunity requires that the anticompetitive conduct of nonsovereign actors, especially those authorized by the State to regulate their own profession, result from procedures that suffice to make it the State’s own.

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See *Goldfarb, supra*, at 790; see also 1A P. Areeda & H. Hovencamp, *Antitrust Law* ¶226, p. 180 (4th ed. 2013) (Areeda & Hovencamp). The question is not whether the challenged conduct is efficient, well-functioning, or wise. See *Ticor, supra*, at 634–635. Rather, it is “whether anti-competitive conduct engaged in by [nonsovereign actors] should be deemed state action and thus shielded from the antitrust laws.” *Patrick v. Burget*, 486 U. S. 94, 100 (1988).

To answer this question, the Court applies the two-part test set forth in *California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc.*, 445 U. S. 97, a case arising from California’s delegation of price-fixing authority to wine merchants. Under *Midcal*, “[a] state law or regulatory scheme cannot be the basis for antitrust immunity unless, first, the State has articulated a clear policy to allow the anticompetitive conduct, and second, the State provides active supervision of [the] anticompetitive conduct.” *Ticor, supra*, at 631 (citing *Midcal, supra*, at 105).

*Midcal*’s clear articulation requirement is satisfied “where the displacement of competition [is] the inherent, logical, or ordinary result of the exercise of authority delegated by the state legislature. In that scenario, the State must have foreseen and implicitly endorsed the anticompetitive effects as consistent with its policy goals.” *Phoebe Putney*, 568 U. S., at \_\_\_\_ (slip op., at 11). The active supervision requirement demands, *inter alia*, “that state officials have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy.” *Patrick, supra*, U. S., at 101.

The two requirements set forth in *Midcal* provide a proper analytical framework to resolve the ultimate question whether an anticompetitive policy is indeed the policy of a State. The first requirement—clear articulation—rarely will achieve that goal by itself, for a policy may

satisfy this test yet still be defined at so high a level of generality as to leave open critical questions about how and to what extent the market should be regulated. See *Ticor*, *supra*, at 636–637. Entities purporting to act under state authority might diverge from the State’s considered definition of the public good. The resulting asymmetry between a state policy and its implementation can invite private self-dealing. The second *Midcal* requirement—active supervision—seeks to avoid this harm by requiring the State to review and approve interstitial policies made by the entity claiming immunity.

*Midcal*’s supervision rule “stems from the recognition that [w]here a private party is engaging in anticompetitive activity, there is a real danger that he is acting to further his own interests, rather than the governmental interests of the State.” *Patrick*, *supra*, at 100. Concern about the private incentives of active market participants animates *Midcal*’s supervision mandate, which demands “realistic assurance that a private party’s anticompetitive conduct promotes state policy, rather than merely the party’s individual interests.” *Patrick*, *supra*, at 101.

## B

In determining whether anticompetitive policies and conduct are indeed the action of a State in its sovereign capacity, there are instances in which an actor can be excused from *Midcal*’s active supervision requirement. In *Hallie v. Eau Claire*, 471 U. S. 34, 45 (1985), the Court held municipalities are subject exclusively to *Midcal*’s “clear articulation” requirement. That rule, the Court observed, is consistent with the objective of ensuring that the policy at issue be one enacted by the State itself. *Hallie* explained that “[w]here the actor is a municipality, there is little or no danger that it is involved in a private price-fixing arrangement. The only real danger is that it will seek to further purely parochial public interests at the

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expense of more overriding state goals.” 471 U. S., at 47. *Hallie* further observed that municipalities are electorally accountable and lack the kind of private incentives characteristic of active participants in the market. See *id.*, at 45, n. 9. Critically, the municipality in *Hallie* exercised a wide range of governmental powers across different economic spheres, substantially reducing the risk that it would pursue private interests while regulating any single field. See *ibid.* That *Hallie* excused municipalities from *Midcal*’s supervision rule for these reasons all but confirms the rule’s applicability to actors controlled by active market participants, who ordinarily have none of the features justifying the narrow exception *Hallie* identified. See 471 U. S., at 45.

Following *Goldfarb*, *Midcal*, and *Hallie*, which clarified the conditions under which *Parker* immunity attaches to the conduct of a nonsovereign actor, the Court in *Columbia v. Omni Outdoor Advertising, Inc.*, 499 U. S. 365, addressed whether an otherwise immune entity could lose immunity for conspiring with private parties. In *Omni*, an aspiring billboard merchant argued that the city of Columbia, South Carolina, had violated the Sherman Act—and forfeited its *Parker* immunity—by anticompetitively conspiring with an established local company in passing an ordinance restricting new billboard construction. 499 U. S., at 367–368. The Court disagreed, holding there is no “conspiracy exception” to *Parker*. *Omni, supra*, at 374.

*Omni*, like the cases before it, recognized the importance of drawing a line “relevant to the purposes of the Sherman Act and of *Parker*: prohibiting the restriction of competition for private gain but permitting the restriction of competition in the public interest.” 499 U. S., at 378. In the context of a municipal actor which, as in *Hallie*, exercised substantial governmental powers, *Omni* rejected a conspiracy exception for “corruption” as vague and unworkable, since “virtually all regulation benefits some

segments of the society and harms others” and may in that sense be seen as “‘corrupt.’” 499 U. S., at 377. *Omni* also rejected subjective tests for corruption that would force a “deconstruction of the governmental process and probing of the official ‘intent’ that we have consistently sought to avoid.” *Ibid.* Thus, whereas the cases preceding it addressed the preconditions of *Parker* immunity and engaged in an objective, *ex ante* inquiry into nonsovereign actors’ structure and incentives, *Omni* made clear that recipients of immunity will not lose it on the basis of ad hoc and *ex post* questioning of their motives for making particular decisions.

*Omni*’s holding makes it all the more necessary to ensure the conditions for granting immunity are met in the first place. The Court’s two state-action immunity cases decided after *Omni* reinforce this point. In *Ticor* the Court affirmed that *Midcal*’s limits on delegation must ensure that “[a]ctual state involvement, not deference to private price-fixing arrangements under the general auspices of state law, is the precondition for immunity from federal law.” 504 U. S., at 633. And in *Phoebe Putney* the Court observed that *Midcal*’s active supervision requirement, in particular, is an essential condition of state-action immunity when a nonsovereign actor has “an incentive to pursue [its] own self-interest under the guise of implementing state policies.” 568 U. S., at \_\_\_ (slip op., at 8) (quoting *Hallie, supra*, at 46–47). The lesson is clear: *Midcal*’s active supervision test is an essential prerequisite of *Parker* immunity for any nonsovereign entity—public or private—controlled by active market participants.

### C

The Board argues entities designated by the States as agencies are exempt from *Midcal*’s second requirement. That premise, however, cannot be reconciled with the Court’s repeated conclusion that the need for supervision

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turns not on the formal designation given by States to regulators but on the risk that active market participants will pursue private interests in restraining trade.

State agencies controlled by active market participants, who possess singularly strong private interests, pose the very risk of self-dealing *Midcal*'s supervision requirement was created to address. See *Areeda & Hovencamp* ¶227, at 226. This conclusion does not question the good faith of state officers but rather is an assessment of the structural risk of market participants' confusing their own interests with the State's policy goals. See *Patrick*, 486 U. S., at 100–101.

The Court applied this reasoning to a state agency in *Goldfarb*. There the Court denied immunity to a state agency (the Virginia State Bar) controlled by market participants (lawyers) because the agency had “joined in what is essentially a private anticompetitive activity” for “the benefit of its members.” 421 U. S., at 791, 792. This emphasis on the Bar's private interests explains why *Goldfarb*, though it predates *Midcal*, considered the lack of supervision by the Virginia Supreme Court to be a principal reason for denying immunity. See 421 U. S., at 791; see also *Hoover*, 466 U. S., at 569 (emphasizing lack of active supervision in *Goldfarb*); *Bates v. State Bar of Ariz.*, 433 U. S. 350, 361–362 (1977) (granting the Arizona Bar state-action immunity partly because its “rules are subject to pointed re-examination by the policymaker”).

While *Hallie* stated “it is likely that active state supervision would also not be required” for agencies, 471 U. S., at 46, n. 10, the entity there, as was later the case in *Omni*, was an electorally accountable municipality with general regulatory powers and no private price-fixing agenda. In that and other respects the municipality was more like prototypical state agencies, not specialized boards dominated by active market participants. In important regards, agencies controlled by market partici-

pants are more similar to private trade associations vested by States with regulatory authority than to the agencies *Hallie* considered. And as the Court observed three years after *Hallie*, “[t]here is no doubt that the members of such associations often have economic incentives to restrain competition and that the product standards set by such associations have a serious potential for anticompetitive harm.” *Allied Tube*, 486 U. S., at 500. For that reason, those associations must satisfy *Midcal*’s active supervision standard. See *Midcal*, 445 U. S., at 105–106.

The similarities between agencies controlled by active market participants and private trade associations are not eliminated simply because the former are given a formal designation by the State, vested with a measure of government power, and required to follow some procedural rules. See *Hallie*, *supra*, at 39 (rejecting “purely formalistic” analysis). *Parker* immunity does not derive from nomenclature alone. When a State empowers a group of active market participants to decide who can participate in its market, and on what terms, the need for supervision is manifest. See *Areeda & Hovenkamp* ¶227, at 226. The Court holds today that a state board on which a controlling number of decisionmakers are active market participants in the occupation the board regulates must satisfy *Midcal*’s active supervision requirement in order to invoke state-action antitrust immunity.

#### D

The State argues that allowing this FTC order to stand will discourage dedicated citizens from serving on state agencies that regulate their own occupation. If this were so—and, for reasons to be noted, it need not be so—there would be some cause for concern. The States have a sovereign interest in structuring their governments, see *Gregory v. Ashcroft*, 501 U. S. 452, 460 (1991), and may conclude there are substantial benefits to staffing their

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agencies with experts in complex and technical subjects, see *Southern Motor Carriers Rate Conference, Inc. v. United States*, 471 U. S. 48, 64 (1985). There is, moreover, a long tradition of citizens esteemed by their professional colleagues devoting time, energy, and talent to enhancing the dignity of their calling.

Adherence to the idea that those who pursue a calling must embrace ethical standards that derive from a duty separate from the dictates of the State reaches back at least to the Hippocratic Oath. See generally S. Miles, *The Hippocratic Oath and the Ethics of Medicine* (2004). In the United States, there is a strong tradition of professional self-regulation, particularly with respect to the development of ethical rules. See generally R. Rotunda & J. Dzienkowski, *Legal Ethics: The Lawyer's Deskbook on Professional Responsibility* (2014); R. Baker, *Before Bioethics: A History of American Medical Ethics From the Colonial Period to the Bioethics Revolution* (2013). Dentists are no exception. The American Dental Association, for example, in an exercise of “the privilege and obligation of self-government,” has “call[ed] upon dentists to follow high ethical standards,” including “honesty, compassion, kindness, integrity, fairness and charity.” American Dental Association, *Principles of Ethics and Code of Professional Conduct* 3–4 (2012). State laws and institutions are sustained by this tradition when they draw upon the expertise and commitment of professionals.

Today's holding is not inconsistent with that idea. The Board argues, however, that the potential for money damages will discourage members of regulated occupations from participating in state government. Cf. *Filarsky v. Delia*, 566 U. S. \_\_\_, \_\_\_ (2012) (slip op., at 12) (warning in the context of civil rights suits that the “the most talented candidates will decline public engagements if they do not receive the same immunity enjoyed by their public employee counterparts”). But this case, which does not

present a claim for money damages, does not offer occasion to address the question whether agency officials, including board members, may, under some circumstances, enjoy immunity from damages liability. See *Goldfarb*, 421 U. S., at 792, n. 22; see also Brief for Respondent 56. And, of course, the States may provide for the defense and indemnification of agency members in the event of litigation.

States, furthermore, can ensure *Parker* immunity is available to agencies by adopting clear policies to displace competition; and, if agencies controlled by active market participants interpret or enforce those policies, the States may provide active supervision. Precedent confirms this principle. The Court has rejected the argument that it would be unwise to apply the antitrust laws to professional regulation absent compliance with the prerequisites for invoking *Parker* immunity:

“[Respondents] contend that effective peer review is essential to the provision of quality medical care and that any threat of antitrust liability will prevent physicians from participating openly and actively in peer-review proceedings. This argument, however, essentially challenges the wisdom of applying the antitrust laws to the sphere of medical care, and as such is properly directed to the legislative branch. To the extent that Congress has declined to exempt medical peer review from the reach of the antitrust laws, peer review is immune from antitrust scrutiny only if the State effectively has made this conduct its own.” *Patrick*, 486 U. S. at 105–106 (footnote omitted).

The reasoning of *Patrick v. Burget* applies to this case with full force, particularly in light of the risks licensing boards dominated by market participants may pose to the free market. See generally Edlin & Haw, *Cartels by Another Name: Should Licensed Occupations Face Antitrust Scrutiny?* 162 U. Pa. L. Rev. 1093 (2014).

## Opinion of the Court

## E

The Board does not contend in this Court that its anti-competitive conduct was actively supervised by the State or that it should receive *Parker* immunity on that basis.

By statute, North Carolina delegates control over the practice of dentistry to the Board. The Act, however, says nothing about teeth whitening, a practice that did not exist when it was passed. After receiving complaints from other dentists about the nondentists' cheaper services, the Board's dentist members—some of whom offered whitening services—acted to expel the dentists' competitors from the market. In so doing the Board relied upon cease-and-desist letters threatening criminal liability, rather than any of the powers at its disposal that would invoke oversight by a politically accountable official. With no active supervision by the State, North Carolina officials may well have been unaware that the Board had decided teeth whitening constitutes “the practice of dentistry” and sought to prohibit those who competed against dentists from participating in the teeth whitening market. Whether or not the Board exceeded its powers under North Carolina law, cf. *Omni*, 499 U. S., at 371–372, there is no evidence here of any decision by the State to initiate or concur with the Board's actions against the nondentists.

## IV

The Board does not claim that the State exercised active, or indeed any, supervision over its conduct regarding nondentist teeth whiteners; and, as a result, no specific supervisory systems can be reviewed here. It suffices to note that the inquiry regarding active supervision is flexible and context-dependent. Active supervision need not entail day-to-day involvement in an agency's operations or micromanagement of its every decision. Rather, the question is whether the State's review mechanisms provide “realistic assurance” that a nonsovereign actor's anticom-

petitive conduct “promotes state policy, rather than merely the party’s individual interests.” *Patrick, supra*, at 100–101; see also *Ticor*, 504 U. S., at 639–640.

The Court has identified only a few constant requirements of active supervision: The supervisor must review the substance of the anticompetitive decision, not merely the procedures followed to produce it, see *Patrick*, 486 U. S., at 102–103; the supervisor must have the power to veto or modify particular decisions to ensure they accord with state policy, see *ibid.*; and the “mere potential for state supervision is not an adequate substitute for a decision by the State,” *Ticor, supra*, at 638. Further, the state supervisor may not itself be an active market participant. In general, however, the adequacy of supervision otherwise will depend on all the circumstances of a case.

\* \* \*

The Sherman Act protects competition while also respecting federalism. It does not authorize the States to abandon markets to the unsupervised control of active market participants, whether trade associations or hybrid agencies. If a State wants to rely on active market participants as regulators, it must provide active supervision if state-action immunity under *Parker* is to be invoked.

The judgment of the Court of Appeals for the Fourth Circuit is affirmed.

*It is so ordered.*

ALITO, J., dissenting

**SUPREME COURT OF THE UNITED STATES**

No. 13–534

NORTH CAROLINA STATE BOARD OF DENTAL  
EXAMINERS, PETITIONER *v.* FEDERAL  
TRADE COMMISSION

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF  
APPEALS FOR THE FOURTH CIRCUIT

[February 25, 2015]

JUSTICE ALITO, with whom JUSTICE SCALIA and JUSTICE THOMAS join, dissenting.

The Court’s decision in this case is based on a serious misunderstanding of the doctrine of state-action antitrust immunity that this Court recognized more than 60 years ago in *Parker v. Brown*, 317 U. S. 341 (1943). In *Parker*, the Court held that the Sherman Act does not prevent the States from continuing their age-old practice of enacting measures, such as licensing requirements, that are designed to protect the public health and welfare. *Id.*, at 352. The case now before us involves precisely this type of state regulation—North Carolina’s laws governing the practice of dentistry, which are administered by the North Carolina Board of Dental Examiners (Board).

Today, however, the Court takes the unprecedented step of holding that *Parker* does not apply to the North Carolina Board because the Board is not structured in a way that merits a good-government seal of approval; that is, it is made up of practicing dentists who have a financial incentive to use the licensing laws to further the financial interests of the State’s dentists. There is nothing new about the structure of the North Carolina Board. When the States first created medical and dental boards, well before the Sherman Act was enacted, they began to staff

them in this way.<sup>1</sup> Nor is there anything new about the suspicion that the North Carolina Board—in attempting to prevent persons other than dentists from performing teeth-whitening procedures—was serving the interests of dentists and not the public. Professional and occupational licensing requirements have often been used in such a way.<sup>2</sup> But that is not what *Parker* immunity is about. Indeed, the very state program involved in that case was unquestionably designed to benefit the regulated entities, California raisin growers.

The question before us is not whether such programs serve the public interest. The question, instead, is whether this case is controlled by *Parker*, and the answer to that question is clear. Under *Parker*, the Sherman Act (and the Federal Trade Commission Act, see *FTC v. Ticor Title Ins. Co.*, 504 U. S. 621, 635 (1992)) do not apply to state agencies; the North Carolina Board of Dental Examiners is a state agency; and that is the end of the matter. By straying from this simple path, the Court has not only distorted *Parker*; it has headed into a morass. Determining whether a state agency is structured in a way that militates against regulatory capture is no easy task, and there is reason to fear that today's decision will spawn confusion. The Court has veered off course, and therefore I cannot go along.

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<sup>1</sup>S. White, *History of Oral and Dental Science in America 197–214* (1876) (detailing earliest American regulations of the practice of dentistry).

<sup>2</sup>See, e.g., R. Shrylock, *Medical Licensing in America* 29 (1967) (Shrylock) (detailing the deterioration of licensing regimes in the mid-19th century, in part out of concerns about restraints on trade); Gellhorn, *The Abuse of Occupational Licensing*, 44 *U. Chi. L. Rev.* 6 (1976); Shepard, *Licensing Restrictions and the Cost of Dental Care*, 21 *J. Law & Econ.* 187 (1978).

ALITO, J., dissenting

## I

In order to understand the nature of *Parker* state-action immunity, it is helpful to recall the constitutional landscape in 1890 when the Sherman Act was enacted. At that time, this Court and Congress had an understanding of the scope of federal and state power that is very different from our understanding today. The States were understood to possess the exclusive authority to regulate “their purely internal affairs.” *Leisy v. Hardin*, 135 U. S. 100, 122 (1890). In exercising their police power in this area, the States had long enacted measures, such as price controls and licensing requirements, that had the effect of restraining trade.<sup>3</sup>

The Sherman Act was enacted pursuant to Congress’ power to regulate interstate commerce, and in passing the Act, Congress wanted to exercise that power “to the utmost extent.” *United States v. South-Eastern Underwriters Assn.*, 322 U. S. 533, 558 (1944). But in 1890, the understanding of the commerce power was far more limited than it is today. See, e.g., *Kidd v. Pearson*, 128 U. S. 1, 17–18 (1888). As a result, the Act did not pose a threat to traditional state regulatory activity.

By 1943, when *Parker* was decided, however, the situation had changed dramatically. This Court had held that the commerce power permitted Congress to regulate even local activity if it “exerts a substantial economic effect on interstate commerce.” *Wickard v. Filburn*, 317 U. S. 111, 125 (1942). This meant that Congress could regulate many of the matters that had once been thought to fall exclusively within the jurisdiction of the States. The new interpretation of the commerce power brought about an expansion of the reach of the Sherman Act. See *Hospital*

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<sup>3</sup>See Handler, The Current Attack on the *Parker v. Brown* State Action Doctrine, 76 Colum. L. Rev. 1, 4–6 (1976) (collecting cases).

*Building Co. v. Trustees of Rex Hospital*, 425 U. S. 738, 743, n. 2 (1976) (“[D]ecisions by this Court have permitted the reach of the Sherman Act to expand along with expanding notions of congressional power”). And the expanded reach of the Sherman Act raised an important question. The Sherman Act does not expressly exempt States from its scope. Does that mean that the Act applies to the States and that it potentially outlaws many traditional state regulatory measures? The Court confronted that question in *Parker*.

In *Parker*, a raisin producer challenged the California Agricultural Prorate Act, an agricultural price support program. The California Act authorized the creation of an Agricultural Prorate Advisory Commission (Commission) to establish marketing plans for certain agricultural commodities within the State. 317 U. S., at 346–347. Raisins were among the regulated commodities, and so the Commission established a marketing program that governed many aspects of raisin sales, including the quality and quantity of raisins sold, the timing of sales, and the price at which raisins were sold. *Id.*, at 347–348. The *Parker* Court assumed that this program would have violated “the Sherman Act if it were organized and made effective solely by virtue of a contract, combination or conspiracy of private persons,” and the Court also assumed that Congress could have prohibited a State from creating a program like California’s if it had chosen to do so. *Id.*, at 350. Nevertheless, the Court concluded that the California program did not violate the Sherman Act because the Act did not circumscribe state regulatory power. *Id.*, at 351.

The Court’s holding in *Parker* was not based on either the language of the Sherman Act or anything in the legislative history affirmatively showing that the Act was not meant to apply to the States. Instead, the Court reasoned that “[i]n a dual system of government in which, under the Constitution, the states are sovereign, save only as Con-

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gress may constitutionally subtract from their authority, an unexpressed purpose to nullify a state’s control over its officers and agents is not lightly to be attributed to Congress.” 317 U. S., at 351. For the Congress that enacted the Sherman Act in 1890, it would have been a truly radical and almost certainly futile step to attempt to prevent the States from exercising their traditional regulatory authority, and the *Parker* Court refused to assume that the Act was meant to have such an effect.

When the basis for the *Parker* state-action doctrine is understood, the Court’s error in this case is plain. In 1890, the regulation of the practice of medicine and dentistry was regarded as falling squarely within the States’ sovereign police power. By that time, many States had established medical and dental boards, often staffed by doctors or dentists,<sup>4</sup> and had given those boards the authority to confer and revoke licenses.<sup>5</sup> This was quintessential police power legislation, and although state laws were often challenged during that era under the doctrine of substantive due process, the licensing of medical professionals easily survived such assaults. Just one year before the enactment of the Sherman Act, in *Dent v. West Virginia*, 129 U. S. 114, 128 (1889), this Court rejected such a challenge to a state law requiring all physicians to obtain a certificate from the state board of health attesting to their qualifications. And in *Hawker v. New York*, 170 U. S. 189, 192 (1898), the Court reiterated that a law

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<sup>4</sup>Shrylock 54–55; D. Johnson and H. Chaudry, *Medical Licensing and Discipline in America* 23–24 (2012).

<sup>5</sup>In *Hawker v. New York*, 170 U. S. 189 (1898), the Court cited state laws authorizing such boards to refuse or revoke medical licenses. *Id.*, at 191–193, n. 1. See also *Douglas v. Noble*, 261 U. S. 165, 166 (1923) (“In 1893 the legislature of Washington provided that only licensed persons should practice dentistry” and “vested the authority to license in a board of examiners, consisting of five practicing dentists”).

specifying the qualifications to practice medicine was clearly a proper exercise of the police power. Thus, the North Carolina statutes establishing and specifying the powers of the State Board of Dental Examiners represent precisely the kind of state regulation that the *Parker* exemption was meant to immunize.

## II

As noted above, the only question in this case is whether the North Carolina Board of Dental Examiners is really a state agency, and the answer to that question is clearly yes.

- The North Carolina Legislature determined that the practice of dentistry “affect[s] the public health, safety and welfare” of North Carolina’s citizens and that therefore the profession should be “subject to regulation and control in the public interest” in order to ensure “that only qualified persons be permitted to practice dentistry in the State.” N. C. Gen. Stat. Ann. §90–22(a) (2013).
- To further that end, the legislature created the North Carolina State Board of Dental Examiners “as the agency of the State for the regulation of the practice of dentistry in th[e] State.” §90–22(b).
- The legislature specified the membership of the Board. §90–22(c). It defined the “practice of dentistry,” §90–29(b), and it set out standards for licensing practitioners, §90–30. The legislature also set out standards under which the Board can initiate disciplinary proceedings against licensees who engage in certain improper acts. §90–41(a).
- The legislature empowered the Board to “maintain an action in the name of the State of North Carolina to perpetually enjoin any person from . . . unlawfully practicing dentistry.” §90–40.1(a). It authorized the Board to conduct investigations and to hire legal

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counsel, and the legislature made any “notice or statement of charges against any licensee” a public record under state law. §§ 90–41(d)–(g).

- The legislature empowered the Board “to enact rules and regulations governing the practice of dentistry within the State,” consistent with relevant statutes. §90–48. It has required that any such rules be included in the Board’s annual report, which the Board must file with the North Carolina secretary of state, the state attorney general, and the legislature’s Joint Regulatory Reform Committee. §93B–2. And if the Board fails to file the required report, state law demands that it be automatically suspended until it does so. *Ibid.*

As this regulatory regime demonstrates, North Carolina’s Board of Dental Examiners is unmistakably a state agency created by the state legislature to serve a prescribed regulatory purpose and to do so using the State’s power in cooperation with other arms of state government.

The Board is not a private or “nonsovereign” entity that the State of North Carolina has attempted to immunize from federal antitrust scrutiny. *Parker* made it clear that a State may not “give immunity to those who violate the Sherman Act by authorizing them to violate it, or by declaring that their action is lawful.” *Ante*, at 7 (quoting *Parker*, 317 U. S., at 351). When the *Parker* Court disapproved of any such attempt, it cited *Northern Securities Co. v. United States*, 193 U. S. 197 (1904), to show what it had in mind. In that case, the Court held that a State’s act of chartering a corporation did not shield the corporation’s monopolizing activities from federal antitrust law. *Id.*, at 344–345. Nothing similar is involved here. North Carolina did not authorize a private entity to enter into an anticompetitive arrangement; rather, North Carolina created a state agency and gave that agency the power to regulate a particular subject affecting public health and

safety.

Nothing in *Parker* supports the type of inquiry that the Court now prescribes. The Court crafts a test under which state agencies that are “controlled by active market participants,” *ante*, at 12, must demonstrate active state supervision in order to be immune from federal antitrust law. The Court thus treats these state agencies like private entities. But in *Parker*, the Court did not examine the structure of the California program to determine if it had been captured by private interests. If the Court had done so, the case would certainly have come out differently, because California conditioned its regulatory measures on the participation and approval of market actors in the relevant industry.

Establishing a prorate marketing plan under California’s law first required the petition of at least 10 producers of the particular commodity. *Parker*, 317 U. S., at 346. If the Commission then agreed that a marketing plan was warranted, the Commission would “select a program committee *from among nominees chosen by the qualified producers.*” *Ibid.* (emphasis added). That committee would then formulate the proration marketing program, which the Commission could modify or approve. But even after Commission approval, the program became law (and then, automatically) only if it gained the approval of 65 percent of the relevant producers, representing at least 51 percent of the acreage of the regulated crop. *Id.*, at 347. This scheme gave decisive power to market participants. But despite these aspects of the California program, *Parker* held that California was acting as a “sovereign” when it “adopt[ed] and enforc[ed] the prorate program.” *Id.*, at 352. This reasoning is irreconcilable with the Court’s today.

### III

The Court goes astray because it forgets the origin of the

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*Parker* doctrine and is misdirected by subsequent cases that extended that doctrine (in certain circumstances) to private entities. The Court requires the North Carolina Board to satisfy the two-part test set out in *California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc.*, 445 U. S. 97 (1980), but the party claiming *Parker* immunity in that case was not a state agency but a private trade association. Such an entity is entitled to *Parker* immunity, *Midcal* held, only if the anticompetitive conduct at issue was both “clearly articulated” and “actively supervised by the State itself.” 445 U. S., at 105. Those requirements are needed where a State authorizes private parties to engage in anticompetitive conduct. They serve to identify those situations in which conduct *by private parties* can be regarded as the conduct of a State. But when the conduct in question is the conduct of a state agency, no such inquiry is required.

This case falls into the latter category, and therefore *Midcal* is inapposite. The North Carolina Board is not a private trade association. It is a state agency, created and empowered by the State to regulate an industry affecting public health. It would not exist if the State had not created it. And for purposes of *Parker*, its membership is irrelevant; what matters is that it is part of the government of the sovereign State of North Carolina.

Our decision in *Hallie v. Eau Claire*, 471 U. S. 34 (1985), which involved Sherman Act claims against a municipality, not a State agency, is similarly inapplicable. In *Hallie*, the plaintiff argued that the two-pronged *Midcal* test should be applied, but the Court disagreed. The Court acknowledged that municipalities “are not themselves sovereign.” 471 U. S., at 38. But recognizing that a municipality is “an arm of the State,” *id.*, at 45, the Court held that a municipality should be required to satisfy only the first prong of the *Midcal* test (requiring a clearly articulated state policy), 471 U. S., at 46. That municipalities

are not sovereign was critical to our analysis in *Hallie*, and thus that decision has no application in a case, like this one, involving a state agency.

Here, however, the Court not only disregards the North Carolina Board's status as a full-fledged state agency; it treats the Board less favorably than a municipality. This is puzzling. States are sovereign, *Northern Ins. Co. of N. Y. v. Chatham County*, 547 U. S. 189, 193 (2006), and California's sovereignty provided the foundation for the decision in *Parker, supra*, at 352. Municipalities are not sovereign. *Jinks v. Richland County*, 538 U. S. 456, 466 (2003). And for this reason, federal law often treats municipalities differently from States. Compare *Will v. Michigan Dept. of State Police*, 491 U. S. 58, 71 (1989) (“[N]either a State nor its officials acting in their official capacities are ‘persons’ under [42 U. S. C.] §1983”), with *Monell v. City Dept. of Social Servs., New York*, 436 U. S. 658, 694 (1978) (municipalities liable under §1983 where “execution of a government's policy or custom . . . inflicts the injury”).

The Court recognizes that municipalities, although not sovereign, nevertheless benefit from a more lenient standard for state-action immunity than private entities. Yet under the Court's approach, the North Carolina Board of Dental Examiners, a full-fledged state agency, is treated like a private actor and must demonstrate that the State actively supervises its actions.

The Court's analysis seems to be predicated on an assessment of the varying degrees to which a municipality and a state agency like the North Carolina Board are likely to be captured by private interests. But until today, *Parker* immunity was never conditioned on the proper use of state regulatory authority. On the contrary, in *Columbia v. Omni Outdoor Advertising, Inc.*, 499 U. S. 365 (1991), we refused to recognize an exception to *Parker* for cases in which it was shown that the defendants had

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engaged in a conspiracy or corruption or had acted in a way that was not in the public interest. *Id.*, at 374. The Sherman Act, we said, is not an anticorruption or good-government statute. 499 U. S., at 398. We were unwilling in *Omni* to rewrite *Parker* in order to reach the allegedly abusive behavior of city officials. 499 U. S., at 374–379. But that is essentially what the Court has done here.

### III

Not only is the Court’s decision inconsistent with the underlying theory of *Parker*; it will create practical problems and is likely to have far-reaching effects on the States’ regulation of professions. As previously noted, state medical and dental boards have been staffed by practitioners since they were first created, and there are obvious advantages to this approach. It is reasonable for States to decide that the individuals best able to regulate technical professions are practitioners with expertise in those very professions. Staffing the State Board of Dental Examiners with certified public accountants would certainly lessen the risk of actions that place the well-being of dentists over those of the public, but this would also compromise the State’s interest in sensibly regulating a technical profession in which lay people have little expertise.

As a result of today’s decision, States may find it necessary to change the composition of medical, dental, and other boards, but it is not clear what sort of changes are needed to satisfy the test that the Court now adopts. The Court faults the structure of the North Carolina Board because “active market participants” constitute “a controlling number of [the] decisionmakers,” *ante*, at 14, but this test raises many questions.

What is a “controlling number”? Is it a majority? And if so, why does the Court eschew that term? Or does the Court mean to leave open the possibility that something less than a majority might suffice in particular circum-

stances? Suppose that active market participants constitute a voting bloc that is generally able to get its way? How about an obstructionist minority or an agency chair empowered to set the agenda or veto regulations?

Who is an “active market participant”? If Board members withdraw from practice during a short term of service but typically return to practice when their terms end, does that mean that they are not active market participants during their period of service?

What is the scope of the market in which a member may not participate while serving on the board? Must the market be relevant to the particular regulation being challenged or merely to the jurisdiction of the entire agency? Would the result in the present case be different if a majority of the Board members, though practicing dentists, did not provide teeth whitening services? What if they were orthodontists, periodontists, and the like? And how much participation makes a person “active” in the market?

The answers to these questions are not obvious, but the States must predict the answers in order to make informed choices about how to constitute their agencies.

I suppose that all this will be worked out by the lower courts and the Federal Trade Commission (FTC), but the Court’s approach raises a more fundamental question, and that is why the Court’s inquiry should stop with an examination of the structure of a state licensing board. When the Court asks whether market participants control the North Carolina Board, the Court in essence is asking whether this regulatory body has been captured by the entities that it is supposed to regulate. Regulatory capture can occur in many ways.<sup>6</sup> So why ask only whether

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<sup>6</sup>See, *e.g.*, R. Noll, *Reforming Regulation* 40–43, 46 (1971); J. Wilson, *The Politics of Regulation* 357–394 (1980). Indeed, it has even been

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the members of a board are active market participants? The answer may be that determining when regulatory capture has occurred is no simple task. That answer provides a reason for relieving courts from the obligation to make such determinations at all. It does not explain why it is appropriate for the Court to adopt the rather crude test for capture that constitutes the holding of today's decision.

#### IV

The Court has created a new standard for distinguishing between private and state actors for purposes of federal antitrust immunity. This new standard is not true to the *Parker* doctrine; it diminishes our traditional respect for federalism and state sovereignty; and it will be difficult to apply. I therefore respectfully dissent.

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charged that the FTC, which brought this case, has been captured by entities over which it has jurisdiction. See E. Cox, "The Nader Report" on the Federal Trade Commission vii–xiv (1969); Posner, Federal Trade Commission, *Chi. L. Rev.* 47, 82–84 (1969).