

**MINUTES**  
**Monthly Meeting**  
**MEDICAL LICENSURE COMMISSION OF ALABAMA**  
**Meeting Location: 848 Washington Avenue**  
**Montgomery, Alabama 36104**

**February 25, 2026**

MEMBERS PRESENT IN PERSON

Jorge Alsip, M.D., Chairman  
Kenneth W. Aldridge, M.D., Vice-Chairman  
Craig H. Christopher, M.D.  
Howard J. Falgout, M.D.  
Nina Nelson-Garrett, M.D.  
James R. Seale, Esq.  
Pamela Varner, M.D.

MEMBERS NOT PRESENT

MLC STAFF

Aaron Dettling, General Counsel, MLC  
Rebecca Robbins, Operations Director (Recording)  
Nicole Roque, Administrative Assistant (Recording)  
Heather Lindemann, Licensure Assistant

OTHERS PRESENT

BME STAFF

Buddy Chavez, Investigator  
Anthony Crenshaw, Investigator  
Amy Dorminey, Director of Operations  
Chris Hart, Technology  
Effie Hawthorne, Associate General Counsel  
Wilson Hunter, General Counsel  
Roland Johnson, Physician Monitoring  
Sally Knight, Physician Monitoring  
Stephen Lavender, Investigator  
William Perkins, Executive Director  
Ben Schlemmer, Investigator  
Tiffany Seamon, Director of Credentialing  
Scott Sides, Investigator



Call to Order: 9:00 a.m.

Prior notice having been given in accordance with the Alabama Open Meetings Act, and with a quorum of seven members present, Commission Chairman, Jorge Alsip, M.D. convened the monthly meeting of the Alabama Medical Licensure Commission.

**OLD BUSINESS**

**Minutes January 28, 2026**

Commissioner Seale made a motion that the Minutes of January 28, 2026, be approved with changes as directed by the Commission. A second was made by Commissioner Varner. The motion was approved by unanimous vote.

**NEW BUSINESS**

**Full License Applicants**

<b><u>Name</u></b>	<b><u>Medical School</u></b>	<b><u>Endorsement</u></b>
1. Ahmed R I Abdelnabi	Benha Zagazig Faculty of Medicine	USMLE/NJ
2. Zaid A T Al Khouri	Jordan University of Science & Technology	USMLE
3. Rabia Ali	Shifa College of Medicine	USMLE/CT
4. William Edward Allen	Medical University of South Carolina College of Medicine	USMLE
5. Bethany Marie Anderson	University of Wisconsin Medical School	USMLE/WI
6. Daniel Antwi-Amoabeng	American University of Antigua	USMLE/LA
7. Maria Nathalia Baste Subia	Catholic University of Santiago de Guayaquil	USMLE/OK
8. Varun Kumar Bavyer	M.S. Ramaiah Medical College	USMLE/IL
9. Adrienne Chandler Bean	University of South Alabama College of Medicine	USMLE/NC
10. Christina Michelle Boulineaux	Harvard Medical School	USMLE
11. Chad Kammer Brady	West Virginia School of Osteopathic Medicine	COMLEX/WV
12. Nikita Reddy Chintam	Dr. N.T.R. University of Health Sciences	USMLE
13. Derrick Joseph Courville	Louisiana State University School of Medicine New Orleans	USMLE/LA
14. Marco Anthony Cunicelli	Edward Via Virginia College of Osteopathic Medicine	COMLEX/PA
15. Thomas Christopher Deer	University of Puerto Rico School of Medicine	USMLE/MI
16. Chelsey Racheal Deloney	University of Alabama School of Medicine Birmingham	USMLE
17. Ingram Davis Easter	University of South Alabama College of Medicine	USMLE
18. Marawan El Nabouly	Case Western Reserve University School of Medicine	USMLE
19. Logan W D Flaxman	St. George's University School of Medicine	USMLE
20. Jeremy Samuel Frederick	Columbia University College of Physicians & Surgeons	USMLE/KY
21. Tayler Frances Gant	Edward Via College of Osteopathic Medicine Auburn	COMLEX/CA
22. Jabez Christian Gondokusumo	Texas A&M Health Science Center College of Medicine	USMLE

  
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<u>Name</u>	<u>Medical School</u>	<u>Endorsement</u>
23. William Earle Harousseau	Emory University School of Medicine	USMLE/UT
24. Wayne Joseph Harsha	Medical University of South Carolina College of Medicine	USMLE/TN
25. Roger King Henry	Rutgers Robert Wood Johnson Medical School	USMLE
26. Juan P Hernandez Gomez	City University of New York Medical School	USMLE/NY
27. Chad Eric Hobbs	William Carey University College of Osteopathic Medicine	COMLEX/LA
28. Joshua Nolen Koerner	Nova Southeastern University College of Osteopathic Med	COMLEX/GA
29. Kevin Michael Lehane	Philadelphia College of Osteopathic Medicine	COMLEX
30. John Allan Lippert	University of Maryland School of Medicine	USMLE/MA
31. Carlos V Lopez Aquino	Caribbean Central University School of Medicine	USMLE
32. Walisa Kaye Maynard	Howard University College of Medicine	USMLE/GA
33. Thomas Joseph Mezzanotte	Georgetown University School of Medicine	USMLE/VA
34. Ryan Steven Morasse	Ponce School of Medicine	USMLE/NY
35. Thomas Scott Moss	Edward Via College of Osteopathic Med, Carolinas Campus	COMLEX
36. Chimeremeze N Ndubuo	Windsor University	USMLE
37. Minh Quan Trong Nguyen	Medical University of Lublin	USMLE
38. Rolf Nyah Tuku Nzalie	University of Yaounde I	USMLE
39. Julia M O'Malley-Keyes	University of Ottawa School of Medicine	USMLE/NY
40. Jorge Alejandro Olan	Drexel University College of Medicine	USMLE
41. Chukwuezugbo K Oranu	Nnamdi Azikiwe University College of Health Sciences	USMLE
42. Vanil Bhadresh Pandya	Ross University School of Medicine	USMLE/MI
43. Suraj Shailesh Patel	St. George's University School of Medicine	USMLE/PA
44. Dawn Marie Pedrotty	Duke University School of Medicine	USMLE/PA
45. Stephen Allan Petty	Lake Erie College of Osteopathic Medicine	COMLEX/NC
46. Anvesh Ravanavena	Kamineni Institute of Medical Sciences	USMLE
47. Michael Triest Reintgen	University of South Florida College of Medicine	USMLE
48. Nathalie J Rodrigues Simoes	Central University of Venezuela - Luis Razetti	COMLEX/MA
49. Shilpa Patel Saxena	University of Florida College of Medicine	USMLE/FL
50. Raees Seedat	Virginia Commonwealth University School of Medicine	USMLE
51. Rae Lynn Sesanto	University of Alabama School of Medicine Birmingham	USMLE
52. Heath Walker Shelton	Alabama College of Osteopathic Medicine	COMLEX
53. Ethan James Shroll	University of Oklahoma Health Science Center	USMLE/NC
54. Suraj Singh	College of Medical Sciences - Nepal	USMLE
55. Magdalena Slomka	Wroclaw Medical University	USMLE/OH
56. Lindsay Marie Snapp	University of Tennessee at Memphis	USMLE
57. Casey Christopher Stanford	University of Mississippi School of Medicine	USMLE/MS
58. Madison Stokes	Augusta University	USMLE
59. Mary Grace Tabakin	Lake Erie College of Osteopathic Medicine	COMLEX/VA
60. Lina Terzian	New York Institute of Technology College of Osteo Medicine	COMLEX
61. Divya M R Thimmareddygar	Sri Deva Raj Urs Medical College	USMLE/NJ
62. Grace Jessica Thole	Alabama College of Osteopathic Medicine	COMLEX
63. Caitlyn Boyett Tomblin	University of Alabama School of Medicine Birmingham	USMLE
64. Karl Louis Toussaint	Lake Erie College of Osteopathic Medicine	COMLEX/AZ

  
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<u>Name</u>	<u>Medical School</u>	<u>Endorsement</u>
65. Nitin Venugopal	Augusta University	USMLE/WA
66. Maria Jose Vera Sanchez	Pontifical Catholic University of Ecuador Faculty of Medicine	USMLE
67. Dennis Dean Walker	Philadelphia College of Osteopathic Medicine	COMLEX/VA
68. Scott Kuanwen Wang	National Yang-Ming Medical College	USMLE/CT
69. Joy Beth West	University of Iowa Carver College of Medicine	FLEX/IL
70. Kathleen McAuley White	Alabama College of Osteopathic Medicine	COMLEX/VA
71. Miguel Alfredo Woodham	University of Wisconsin Medical School	USMLE/CA
72. Vincent Edouard Zimmern	University of Texas Southwestern Medical Center at Dallas	USMLE/TN
73. *Sahil Bawa	Adesh Institute of Medical Sciences & Research	USMLE
74. *Alexis I. Griffin Bonhomme	University of South Alabama College of Medicine	USMLE/MA
75. *David L. Doster	Lincoln Memorial Univ Debusk College of Osteo Med	COMLEX
76. Eldad Joseph Hadar	Univ of Minnesota Medical School – Minneapolis	NBME/WI
77. Jared Lamar Hall	Alabama College of Osteopathic Medicine	COMLEX
78. *Anthony M. Harris	University of Rochester School of Medicine	USMLE/OH
79. *Richard A. Hemings	University of South Carolina College of Medicine	USMLE/MS
80. Ryan M. Hodgeman	Michigan State Univ College of Osteopathic Med	COMLEX/SC
81. Joseph S. Hurst	Rosalind Franklin University of Medicine and Science	NBME/GA
82. *Arpitha R. Jammula	American University of Antigua	USMLE
83. Carey P. Johnson	University of South Alabama College of Medicine	USMLE
84. Ann De Jong	St. George's University	USMLE
85. *Akanchha Khadka	Nepal Medical College	USMLE
86. Babu S. Panickessery	Andhra Medical College	USMLE
87. *Vlatka S. Plymale	West Virginia School of Osteopathic Medicine	COMLEX/TN
88. *Larry C. Stutts	Alabama College of Osteopathic Medicine	COMLEX

*\*Approved pending acceptance and payment of NDC issued by the BME.*

A motion was made by Commissioner Aldridge with a second by Commissioner Christopher to approve applicant numbers one through eighty-eight (1-88) for full licensure. The motion was approved by unanimous vote.

Limited License Applicants

	<u>Name</u>	<u>Medical School</u>	<u>End.</u>	<u>Location</u>	<u>License</u>
1.	Fatima Abid	Shifa College of Medicine	LL/AL	Mobile Infirmiry IM	R
2.	Utsab Adhikari	Tribhuvan University	LL/AL	Flowers Hospital IM	R
3.	Waseh Ahsan	Allama Iqbal Medical College	LL/AL	Flowers Hospital IM	R
4.	Ahmed A Y Alhassan	University Of Khartoum	LL/AL	UAB Montgomery Psychiatry	SP
5.	Fareed Baksh	Allama Iqbal Medical College	LL/AL	Flowers Hospital IM	R
6.	Vikarsh Bhardwaj	Jawaharlal Nehru Med College, Aligarh	LL/AL	Flowers Hospital IM	R
7.	Mark V V Demayo	VCOM Auburn	LL/AL	UAB St. Vincent FM	R
8.	Anam Farrukh	Rawalpindi Med College, U of the Punjab	LL/AL	NAMC IM	R
9.	Usman Ghani	Kabir Medical College	LL/AL	Mobile Infirmiry IM	R
10.	Harwinder S Gill	American University of Antigua	LL/AL	Flowers Hospital IM	R
11.	Taylor N Golden	University of Alabama at Birmingham	LL/AL	UAB St. Vincent's FM	R
12.	Karina Halilova	Second Tashkent State Medical Institute	LL/AL	Crestwood FM	R
13.	Rida Haq	King Edward Medical University	LL/AL	NAMC IM	R
14.	Gursharan Kaur	University of Dhaka	LL/AL	NAMC IM	R
15.	Shreyjit Kaur	Government Medical College Patiala	LL/AL	Flowers Hospital IM	R
16.	Thien D Le-Nguyen	Univ of Med & Pharm of Ho Chi Minh City	LL/AL	Mobile Infirmiry IM	R
17.	Sae-Jong Oum	St. George's Univ School of Med, Grenada	LL/AL	NAMC IM	R
18.	Armando L Perez	U of Washington School of Med - Idaho	LL/AL	USA Health Neurology	R
19.	Walaa A H Saeed	UMST Faculty of Medicine	LL/AL	Baptist Health Birmingham IM	R
20.	Chithra Sreenivasan	Government Medical College Ernakulam	LL/AL	USA Health FM	R
21.	Rachelanne Talatala	U of the East, Magsaysay Mem Med Ctr	LL/AL	USA Health Pediatrics	R
22.	Christopher H Vance	Philadelphia College of Osteo Medicine	LL/AL	UAB St. Vincent's FM	R
23.	Amulya Vazrala	Dr. N.T.R. University of Health Sciences	LL/AL	Mobile Infirmiry FM	R

A motion was made by Commissioner Aldridge with a second by Commissioner Nelson-Garrett to approve applicant numbers one through twenty-three (1-23) for limited licensure. The motion was approved by unanimous vote.

### IMLCC Report

The Commission received as information a report of the licenses that were issued via the Interstate Medical Licensure Compact from January 1, 2026, through January 31, 2026. A copy of this report is attached as Exhibit "A".

### REPORTS

#### Physician Monitoring Report

The Commission received as information the physician monitoring report dated February 24, 2026. A copy of the report is attached as Exhibit "B".

  
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## 2025 Annual Report

The Commission received as information the MLC's 2025 Annual Report. A copy of the report is attached as Exhibit "C".

## APPLICANTS FOR REVIEW

### Patrice L.R. Bright, M.D.

A motion was made by Commissioner Christopher with a second by Commissioner Nelson-Garrett to approve Dr. Bright's application for full licensure. The motion was approved by unanimous vote.

## DISCUSSION ITEMS

### Resolution for Commissioner Paul M. Nagrodzki, M.D.

The Commission presented former Commissioner Nagrodzki with a resolution outlining the many achievements of his dedicated work in public service. A motion was made by Commissioner Christopher with a second by Commissioner Seale to approve the proposed resolution. This resolution was adopted by the Commission in honor of Dr. Nagrodzki's eight years of honorable service to the Medical Licensure Commission of Alabama. A copy of the resolution is attached as Exhibit "D".

### CME Reprimand Removal

The Commission received a report from Rebecca Robbins regarding the progress of the CME Reprimand Removal project assigned to staff at the Commission's November 2025 meeting. At the conclusion of the discussion, a motion was made by Commissioner Nelson-Garrett with a second by Commissioner Falgout to move forward with the project's second phase by filing Revision-to-Action reports with the National Practitioner Data Bank for the 206 qualifying physicians.

### Draft Revisions to the Alabama Administrative Rule 545-X-4-.06: Unprofessional Conduct

The Commission reviewed proposed revisions to Ala. Admin. Code r. 545-X-4-.06. A motion was made by Commissioner Christopher with a second by Commissioner Nelson-Garrett to approve the proposed rule revision for initial notice and public comment. The motion was approved by unanimous vote.

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Draft Revisions to the Alabama Administrative Rule 545-X-4-.10: Registered Mailing Address; Service of Pleadings, Notices and Other Papers

The Commission reviewed proposed revisions to Ala. Admin. Code r. 545-X-4-.10. A motion was made by Commissioner Aldridge with a second by Commissioner Christopher to approve the proposed rule revision for initial notice and public comment. The motion was approved by unanimous vote.

Draft Revisions to the Alabama Administrative Rule 545-X-3-.03: Initiation of A Contest Case; Notice and Opportunity for Hearing in Contested Cases; Contents of Notice; Procedure Upon Failure of Notified Party to Appear; Presentation of Evidence and Argument; Right to Counsel; Disposition by Stipulation; Settlement; Contents of Record; Public Attendance at Oral Proceedings; Recordings and Transcripts of Oral Proceeding

The Commission reviewed proposed revisions to Ala. Admin. Code r. 545-X-3-.03. A motion was made by Commissioner Christopher with a second by Commissioner Seale to approve the proposed rule revision for initial notice and public comment. The motion was approved by unanimous vote.

Draft Revisions to the Alabama Administrative Rule 545-X-3-.08: Appointment and Authority of Hearing Officer and Legal Counsel; Grounds for Suspension or Revocation of License

The Commission reviewed proposed revisions to Ala. Admin. Code r. 545-X-3-.08. A motion was made by Commissioner Nelson-Garrett with a second by Commissioner Christopher to approve the proposed rule revision for initial notice and public comment. The motion was approved by unanimous vote. A copy of the memorandum for all listed draft revisions is attached hereto as Exhibit "E".

FSMB Call for Comments: Reports and Recommendations of the FSMB Workgroup on Oversight of Clinical-Decision Making

The Commission received as information the Federation of State Medical Boards Call for Comments: Reports and Recommendations of the Federation of State Medical Boards Workgroup on Oversight of Clinical-Decision Making. A copy of the memorandum is attached hereto as Exhibit "F".

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**FSMB Call for Comments: Reports on Physician Collective Bargaining and Unionization**

The Commission received as information the Federation of State Medical Boards Call for Comments: Reports on Physician Collective Bargaining and Unionization. A copy of the memorandum is attached hereto as Exhibit "G".

**ADMINISTRATIVE FILINGS**

**Timothy J. Ramsden, M.D.**

The Commission received as information the Statement of Contentions filed by Aaron Dettling, General Counsel for the Commission, regarding the upcoming hearing in the matter. A copy of the statement is attached hereto as Exhibit "H".

**CLOSED SESSION UNDER ALA. CODE 34-24-361.1**

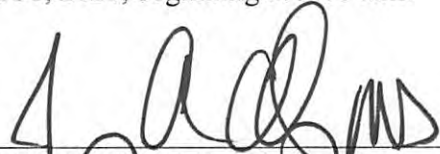
At 10:46 a.m., the Commission entered closed session pursuant to Alabama Code § 34-24-361.1 to hear and consider the following matters:


**Steven M. Taylor, M.D.**

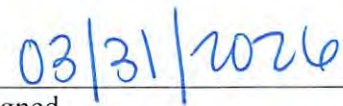
The Commission received a proposed Joint Settlement Agreement and Consent Order between Dr. Taylor and the Alabama State Board of Medical Examiners. A motion was made by Commissioner Seale with a second by Commissioner Nelson-Garrett to accept the Joint Settlement Agreement and to enter a Consent Decree incorporating its terms. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "I".

Meeting adjourned at 11:00 a.m.

**PUBLIC MEETING NOTICE:** The next meeting of the Alabama Medical Licensure Commission was announced for Tuesday, March 31, 2026, beginning at 9:00 a.m.

  
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JORGE AL SIR, M.D., Chairman  
Alabama Medical Licensure Commission

  
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Rebecca Robbins, Director of Operations  
Recording Secretary  
Alabama Medical Licensure Commission

  
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Date Signed

EXHIBIT

A

## IMLCC Licenses Issued January 1, 2026 - January 31, 2026 (235)

Name	License Type	License Number	Status	Issue Date	Expiration Date	State of Primary Licensure
Joseph P Shortall	DO	4492	Active	1/27/2026	12/31/2026	Arizona
Matthew Reed Powell	MD	53070	Active	1/6/2026	12/31/2026	Arizona
Enrique Rodriguez	MD	53095	Active	1/9/2026	12/31/2026	Arizona
Rayette Pollard Casiano	MD	53132	Active	1/13/2026	12/31/2026	Arizona
Brandon Joseph Lawrence	MD	53175	Active	1/20/2026	12/31/2026	Arizona
Mary Buns	MD	53220	Active	1/27/2026	12/31/2026	Arizona
Karng Seng Log	DO	4470	Active	1/6/2026	12/31/2026	Colorado
Brooke M Walls	DO	4504	Active	1/30/2026	12/31/2026	Colorado
James Dominci Grady	MD	53004	Active	1/1/2026	12/31/2026	Colorado
Moody Mihyu	MD	53005	Active	1/1/2026	12/31/2026	Colorado
David Michael Whiting	MD	53062	Active	1/6/2026	12/31/2026	Colorado
Michael Mullin	MD	53086	Active	1/8/2026	12/31/2026	Colorado
Alexander Clinkenbeard	MD	53105	Active	1/9/2026	12/31/2026	Colorado
Kudzai Dumbo	MD	53215	Active	1/27/2026	12/31/2026	Colorado
Robert Fumento	MD	53121	Active	1/12/2026	12/31/2026	Delaware
Jani Wilkerson	DO	4484	Active	1/15/2026	12/31/2026	Florida
Adeeb Saleh	DO	4485	Active	1/20/2026	12/31/2026	Florida
Abdel Ghani Anabtawi	MD	52992	Active	1/1/2026	12/31/2026	Florida
Thomas Conroy	MD	52990	Active	1/1/2026	12/31/2026	Florida
Robert A Honegger	MD	52991	Active	1/1/2026	12/31/2026	Florida
Clauden Louis	MD	52987	Active	1/1/2026	12/31/2026	Florida
Okeefe Lauchland Simmons	MD	52988	Active	1/1/2026	12/31/2026	Florida
Mena Tawadrous	MD	53001	Active	1/1/2026	12/31/2026	Florida
Joao C Fontoura Jr	MD	53045	Active	1/5/2026	12/31/2026	Florida
Carey Dellock	MD	53068	Active	1/6/2026	12/31/2026	Florida
Mariana Yaneth Infante Quintero	MD	53063	Active	1/6/2026	12/31/2026	Florida
Constance Lorraine Jackson	MD	53069	Active	1/6/2026	12/31/2026	Florida
Lorraine Noreen Mitchell	MD	53065	Active	1/6/2026	12/31/2026	Florida
Aaron Cooks	MD	53082	Active	1/7/2026	12/31/2026	Florida
Wander Hurtado Martinez	MD	53088	Active	1/8/2026	12/31/2026	Florida
Jonathan C Trent	MD	53102	Active	1/9/2026	12/31/2026	Florida

Leopoldo Alberto Cordova Garcia	MD	53164	Active	1/16/2026	12/31/2026	Florida
Gustavo Ferrer Gonzalez	MD	53163	Active	1/16/2026	12/31/2026	Florida
Jennifer Burke Johnson	MD	53162	Active	1/16/2026	12/31/2026	Florida
Irshad Ahmed Siddiqui	MD	53157	Active	1/16/2026	12/31/2026	Florida
Juan M Canabal	MD	53176	Active	1/20/2026	12/31/2026	Florida
Samyr Elbadri	MD	53172	Active	1/20/2026	12/31/2026	Florida
Giovanni Ricardo Jubiz	MD	53174	Active	1/20/2026	12/31/2026	Florida
Carlos Penaherrera	MD	53169	Active	1/20/2026	12/31/2026	Florida
Mina Tharwat Shaker	MD	53173	Active	1/20/2026	12/31/2026	Florida
Brendan M Filardo	MD	53198	Active	1/21/2026	12/31/2026	Florida
Brian Rami Kohen	MD	53195	Active	1/21/2026	12/31/2026	Florida
Jennifer Imara Hayes-Bethel	MD	53202	Active	1/22/2026	12/31/2026	Florida
Matthew Hasford	MD	53225	Active	1/27/2026	12/31/2026	Florida
Lisbet D Suarez	MD	53224	Active	1/27/2026	12/31/2026	Florida
Aunna Pourang	MD	53311	Active	1/30/2026	12/31/2026	Florida
Timothy Lee Heilmann	DO	4487	Active	1/20/2026	12/31/2026	Georgia
Shane McTighe	DO	4486	Active	1/20/2026	12/31/2026	Georgia
Katherine Wonneberger Gardner	MD	52998	Active	1/1/2026	12/31/2026	Georgia
Darius Watts	MD	53007	Active	1/1/2026	12/31/2026	Georgia
Onameyore Utuama	MD	53073	Active	1/7/2026	12/31/2026	Georgia
James Whitaker	MD	53083	Active	1/7/2026	12/31/2026	Georgia
Randy M Kiriluk	MD	53100	Active	1/9/2026	12/31/2026	Georgia
Ciela Edith Lopez Armstrong	MD	53118	Active	1/12/2026	12/31/2026	Georgia
Nadria Lyn	MD	53130	Active	1/13/2026	12/31/2026	Georgia
Aminah Danielle Phelps	MD	53127	Active	1/13/2026	12/31/2026	Georgia
Wakitha A Griffin	MD	53142	Active	1/14/2026	12/31/2026	Georgia
Leland Gyr	MD	53159	Active	1/16/2026	12/31/2026	Georgia
Okah Anyokwu	MD	53178	Active	1/20/2026	12/31/2026	Georgia
Malini Ganesh	MD	53177	Active	1/20/2026	12/31/2026	Georgia
Tomas Kuprys	MD	53186	Active	1/20/2026	12/31/2026	Georgia
Vinod Raman	MD	53180	Active	1/20/2026	12/31/2026	Georgia
Harendra Nirmal Fernando	MD	53192	Active	1/21/2026	12/31/2026	Georgia
Alifaiz Saiyed	MD	53190	Active	1/21/2026	12/31/2026	Georgia

Jennifer Setlik	MD	53189	Active	1/21/2026	12/31/2026	Georgia
AvineshSingh Bhar Jaswindar Singh	MD	53218	Active	1/27/2026	12/31/2026	Georgia
Danielle Ibelema	MD	53216	Active	1/27/2026	12/31/2026	Georgia
Carlos Henrique Silva	MD	53219	Active	1/27/2026	12/31/2026	Georgia
Mary Fowler Boyce	MD	53229	Active	1/28/2026	12/31/2026	Georgia
Howard Herman	MD	53303	Active	1/29/2026	12/31/2026	Georgia
Nand Vinod Patel	MD	53300	Active	1/29/2026	12/31/2026	Georgia
Maureen Nwaokolo	MD	53312	Active	1/30/2026	12/31/2026	Georgia
Angeline N Beltsos	MD	53054	Active	1/5/2026	12/31/2026	Illinois
Kashif Ajaz Janjua	MD	53122	Active	1/12/2026	12/31/2026	Illinois
Elizabeth Anne Lowden	MD	53138	Active	1/13/2026	12/31/2026	Illinois
Martins Adeoye	MD	53161	Active	1/16/2026	12/31/2026	Illinois
Ezekiel Aaron Richardson	MD	53170	Active	1/20/2026	12/31/2026	Illinois
Ruta Pangonyte	MD	53208	Active	1/23/2026	12/31/2026	Illinois
Elizabeth Ann Schowe	MD	53106	Active	1/9/2026	12/31/2026	Indiana
Katie Trammel	MD	53112	Active	1/9/2026	12/31/2026	Indiana
Punam Raghove	MD	53135	Active	1/13/2026	12/31/2026	Indiana
Karampal Singh	MD	53134	Active	1/13/2026	12/31/2026	Indiana
Stacy Lynn Fernandez	MD	53040	Active	1/5/2026	12/31/2026	Louisiana
Cheryl Williams	MD	53133	Active	1/13/2026	12/31/2026	Louisiana
Emily Louise Alden Winter	MD	53150	Active	1/15/2026	12/31/2026	Louisiana
Jennifer Lynn Lavie	MD	53179	Active	1/20/2026	12/31/2026	Louisiana
Gerald Max Stell	MD	53168	Active	1/20/2026	12/31/2026	Louisiana
Joseph David Nathan	MD	53199	Active	1/21/2026	12/31/2026	Louisiana
Douglas Terry Mehaffie	MD	53310	Active	1/30/2026	12/31/2026	Louisiana
Sonia Nain Singh	MD	52996	Active	1/1/2026	12/31/2026	Maryland
Ariel Zohar Benor	MD	53043	Active	1/5/2026	12/31/2026	Maryland
Alexander Dao	MD	53129	Active	1/13/2026	12/31/2026	Maryland
Kenneth Neil Josovitz	MD	53148	Active	1/14/2026	12/31/2026	Maryland
Olayiwola Akeem Bolaji	MD	53171	Active	1/20/2026	12/31/2026	Maryland
Mohamad Ali Sadek	DO	4460	Active	1/1/2026	12/31/2026	Michigan
Diana Bitner	MD	53009	Active	1/1/2026	12/31/2026	Michigan
Farris Farid Gulli	MD	53003	Active	1/1/2026	12/31/2026	Michigan

Megan Ann Yee	MD	52999	Active	1/1/2026	12/31/2026	Michigan
Duston Wayne Boyd	MD	53090	Active	1/8/2026	12/31/2026	Michigan
Joseph John Currier	MD	53103	Active	1/9/2026	12/31/2026	Michigan
Jacob Warner Simpson	MD	53136	Active	1/13/2026	12/31/2026	Michigan
Robert Frank	MD	53182	Active	1/20/2026	12/31/2026	Michigan
Victoria Alana Haddad	MD	53184	Active	1/20/2026	12/31/2026	Michigan
Patricia Marilyn Reilly	MD	53200	Active	1/21/2026	12/31/2026	Michigan
Charles Allen Svendsen	MD	53079	Active	1/7/2026	12/31/2026	Minnesota
Doron Michael Spierer	MD	53146	Active	1/14/2026	12/31/2026	Minnesota
John Luther Boone	MD	53204	Active	1/22/2026	12/31/2026	Minnesota
Matthew James Hileman	DO	4488	Active	1/21/2026	12/31/2026	Missouri
Elizabeth VonderHaar	MD	52994	Active	1/1/2026	12/31/2026	Missouri
Robert Marc Forstot	MD	53041	Active	1/5/2026	12/31/2026	Missouri
Kurtis Scott Cox	MD	53230	Active	1/28/2026	12/31/2026	Missouri
Daniel Paul Davis	MD	53301	Active	1/29/2026	12/31/2026	Montana
Cindy Ann Gubbels	MD	53074	Active	1/7/2026	12/31/2026	Nebraska
Pierre Jaime Antoine Gonsalves	MD	53060	Active	1/6/2026	12/31/2026	Nevada
Miguel Angel Villagra Diaz	MD	53119	Active	1/12/2026	12/31/2026	Nevada
Trenton Tyler Sensiba	DO	4491	Active	1/27/2026	12/31/2026	New Hampshire
Richard Christopher Campin	MD	53144	Active	1/14/2026	12/31/2026	New Hampshire
Chrystene An Nguyen	MD	53156	Active	1/15/2026	12/31/2026	New Hampshire
Aysha Azam	DO	4459	Active	1/1/2026	12/31/2026	New Jersey
Robert Gerard Dart	MD	53101	Active	1/9/2026	12/31/2026	New Jersey
Miguel Jose Giron	MD	53165	Active	1/16/2026	12/31/2026	New Jersey
Ihab Ibrahim Ibrahim	MD	53166	Active	1/16/2026	12/31/2026	New Jersey
Joseph Casey Guthrie	MD	53206	Active	1/23/2026	12/31/2026	New Jersey
Hashem Awni Hassan Ayyed	MD	53221	Active	1/27/2026	12/31/2026	New Jersey
Stephen Vogel	MD	53308	Active	1/30/2026	12/31/2026	New Jersey
Biju Babu	MD	53299	Active	1/29/2026	12/31/2026	North Carolina
Lorrie Jean Oldham	DO	4475	Active	1/7/2026	12/31/2026	Ohio
Pryanshi Patel	MD	53089	Active	1/8/2026	12/31/2026	Ohio
Neeraj Satyaprakash Chimanji	MD	53154	Active	1/15/2026	12/31/2026	Ohio
Alexis Rachelle Harvey	MD	53149	Active	1/15/2026	12/31/2026	Ohio

Brian Steven Schloss	MD	53201	Active	1/22/2026	12/31/2026	Ohio
Michael J Paley	MD	53209	Active	1/23/2026	12/31/2026	Ohio
Marc Allen Futernick	MD	53227	Active	1/27/2026	12/31/2026	Ohio
Royce Lee Bargas	DO	4482	Active	1/12/2026	12/31/2026	Oklahoma
Omar Mohammed Hussein	MD	53188	Active	1/21/2026	12/31/2026	Oklahoma
Alireza Ghezavati	MD	53217	Active	1/27/2026	12/31/2026	Oklahoma
Pavel Itersky	DO	4458	Active	1/1/2026	12/31/2026	Pennsylvania
Barbara Tyler Williams-Page	DO	4476	Active	1/8/2026	12/31/2026	Pennsylvania
Stephen Bruno Iorfido	DO	4481	Active	1/9/2026	12/31/2026	Pennsylvania
Franklin Paul Bizousky	DO	4490	Active	1/23/2026	12/31/2026	Pennsylvania
Muhammad Sulman Bhatti	MD	52995	Active	1/1/2026	12/31/2026	Pennsylvania
Rodney Leland Coldren	MD	52997	Active	1/1/2026	12/31/2026	Pennsylvania
Ravindranath Kolli	MD	53008	Active	1/1/2026	12/31/2026	Pennsylvania
Matthew Stephen Staum	MD	53000	Active	1/1/2026	12/31/2026	Pennsylvania
Tiffany Grace Yuh	MD	53055	Active	1/5/2026	12/31/2026	Pennsylvania
Alina Iovleva	MD	53058	Active	1/6/2026	12/31/2026	Pennsylvania
Nazia Khan	MD	53059	Active	1/6/2026	12/31/2026	Pennsylvania
Waleed Shahzad Malik	MD	53064	Active	1/6/2026	12/31/2026	Pennsylvania
Christian Aaron Olivo Freitas	MD	53061	Active	1/6/2026	12/31/2026	Pennsylvania
Luis Nadal	MD	53081	Active	1/7/2026	12/31/2026	Pennsylvania
Raminder Singh Cheema	MD	53091	Active	1/8/2026	12/31/2026	Pennsylvania
Thomas Savage	MD	53145	Active	1/14/2026	12/31/2026	Pennsylvania
Neel Bankim Shah	MD	53309	Active	1/30/2026	12/31/2026	Pennsylvania
Alireza Shirazian	MD	53205	Active	1/22/2026	12/31/2026	South Dakota
Alin Gragossian	DO	4503	Active	1/29/2026	12/31/2026	Tennessee
David Kenji McGregor	MD	53120	Active	1/12/2026	12/31/2026	Tennessee
Renaë Melissa Thomas	MD	53117	Active	1/12/2026	12/31/2026	Tennessee
Joanna R Krause	MD	53143	Active	1/14/2026	12/31/2026	Tennessee
Mark Owusu	MD	53151	Active	1/15/2026	12/31/2026	Tennessee
Brian Anthony Carpenter	MD	53183	Active	1/20/2026	12/31/2026	Tennessee
Jonathan Greer	MD	53185	Active	1/20/2026	12/31/2026	Tennessee
Rachel Parker	MD	53181	Active	1/20/2026	12/31/2026	Tennessee
Jade Jarnee Harris	MD	53187	Active	1/21/2026	12/31/2026	Tennessee

Obinna Emmanuel Daniel	MD	53210	Active	1/23/2026	12/31/2026	Tennessee
Annie Naik Gadiparthi	MD	53226	Active	1/27/2026	12/31/2026	Tennessee
Billy Jones	MD	53228	Active	1/27/2026	12/31/2026	Tennessee
Tara Louise Gustilo	MD	53313	Active	1/30/2026	12/31/2026	Tennessee
Aditya Shah	DO	4471	Active	1/6/2026	12/31/2026	Texas
Amanda Kathryn Beretta	DO	4479	Active	1/9/2026	12/31/2026	Texas
Vivian Mai Hathuc	DO	4478	Active	1/9/2026	12/31/2026	Texas
Victoria Allon Nutting	DO	4480	Active	1/9/2026	12/31/2026	Texas
Panarat Pongsakul	DO	4489	Active	1/22/2026	12/31/2026	Texas
Santos Cantu Jr	MD	52986	Active	1/1/2026	12/31/2026	Texas
Lisa-Gail Thomas Charles	MD	53006	Active	1/1/2026	12/31/2026	Texas
Xinwei Liu	MD	53002	Active	1/1/2026	12/31/2026	Texas
Peter Andrew Lowry	MD	53011	Active	1/1/2026	12/31/2026	Texas
Joyce Merle Shotwell	MD	52993	Active	1/1/2026	12/31/2026	Texas
Rashmi Thapa	MD	52989	Active	1/1/2026	12/31/2026	Texas
Ehizogie Edigin	MD	53037	Active	1/2/2026	12/31/2026	Texas
Jared Hayden Mataska	MD	53042	Active	1/5/2026	12/31/2026	Texas
Amit Babulal Mori	MD	53044	Active	1/5/2026	12/31/2026	Texas
Amy Suporn Asandra	MD	53067	Active	1/6/2026	12/31/2026	Texas
Nicole Baranda Balmaceda	MD	53075	Active	1/7/2026	12/31/2026	Texas
Neil D Gross	MD	53078	Active	1/7/2026	12/31/2026	Texas
Jung-Hoon Kim	MD	53077	Active	1/7/2026	12/31/2026	Texas
Adetomiwa I Ogundere	MD	53080	Active	1/7/2026	12/31/2026	Texas
Jose Alejandro Rauh-Hain	MD	53076	Active	1/7/2026	12/31/2026	Texas
Charles David DuBose	MD	53087	Active	1/8/2026	12/31/2026	Texas
Christine Burgess	MD	53094	Active	1/9/2026	12/31/2026	Texas
Daniel Gibbey	MD	53099	Active	1/9/2026	12/31/2026	Texas
Dana Claire Gingell	MD	53097	Active	1/9/2026	12/31/2026	Texas
Lesley Elizabeth Hamilton-Fox	MD	53098	Active	1/9/2026	12/31/2026	Texas
Jennifer Marie Kaplan	MD	53110	Active	1/9/2026	12/31/2026	Texas
Mohammad Khair Khedr	MD	53096	Active	1/9/2026	12/31/2026	Texas
Emmanuel Ayodele Oke Jr	MD	53111	Active	1/9/2026	12/31/2026	Texas
Dorcas Mokandu Omari	MD	53107	Active	1/9/2026	12/31/2026	Texas

Aaron Shafer	MD	53104	Active	1/9/2026	12/31/2026	Texas
Koichi Takahashi	MD	53109	Active	1/9/2026	12/31/2026	Texas
Horiana Bogdana Grosu	MD	53113	Active	1/12/2026	12/31/2026	Texas
Carol Ming Lewis	MD	53115	Active	1/12/2026	12/31/2026	Texas
Laurence David Rhines	MD	53116	Active	1/12/2026	12/31/2026	Texas
Jeanette Ruiz	MD	53123	Active	1/12/2026	12/31/2026	Texas
Padmanee Sharma	MD	53114	Active	1/12/2026	12/31/2026	Texas
Isis Vanessa Lopez	MD	53131	Active	1/13/2026	12/31/2026	Texas
Vivek Punjabi	MD	53137	Active	1/13/2026	12/31/2026	Texas
Nida Shahzad Safdar	MD	53124	Active	1/13/2026	12/31/2026	Texas
Stell Patadji Santiago	MD	53125	Active	1/13/2026	12/31/2026	Texas
Sarvari Venkata Yellapragada	MD	53128	Active	1/13/2026	12/31/2026	Texas
Hui Zhu	MD	53126	Active	1/13/2026	12/31/2026	Texas
Ammar Hashmi	MD	53147	Active	1/14/2026	12/31/2026	Texas
Jesse Joshua Smith	MD	53141	Active	1/14/2026	12/31/2026	Texas
Abenaa Marcia Brewster	MD	53152	Active	1/15/2026	12/31/2026	Texas
Alina Milian Ramos	MD	53153	Active	1/15/2026	12/31/2026	Texas
Fateeha Furqan	MD	53160	Active	1/16/2026	12/31/2026	Texas
Nneoma Benedicta Oparaji	MD	53158	Active	1/16/2026	12/31/2026	Texas
Ashley Parkinson Craddock	MD	53197	Active	1/21/2026	12/31/2026	Texas
Mark Patrick Hamilton	MD	53193	Active	1/21/2026	12/31/2026	Texas
Meeta Kaur Kanwar	MD	53196	Active	1/21/2026	12/31/2026	Texas
Mohammad Abdullah Ridha	MD	53191	Active	1/21/2026	12/31/2026	Texas
Austin Nizar Baraki	MD	53203	Active	1/22/2026	12/31/2026	Texas
Magdelene Amoateng	MD	53212	Active	1/23/2026	12/31/2026	Texas
Claire Bishop Cummins	MD	53207	Active	1/23/2026	12/31/2026	Texas
Karen Rakers	MD	53211	Active	1/23/2026	12/31/2026	Texas
Emmanuel Oluwaseyi Sonaike	MD	53213	Active	1/23/2026	12/31/2026	Texas
Kurt Leonard Fraivillig	MD	53222	Active	1/27/2026	12/31/2026	Texas
Ki Young Shin	MD	53307	Active	1/30/2026	12/31/2026	Texas
Paula Marincola Smith	MD	53314	Active	1/30/2026	12/31/2026	Texas
Asra Fatima Khan	MD	53066	Active	1/6/2026	12/31/2026	Utah
Jeffrey Lee Mathews	MD	53223	Active	1/27/2026	12/31/2026	Utah

Karl Lorenzo Brown	MD	53298	Active	1/28/2026	12/31/2026	Utah
Tammy Sue Fouse	DO	4461	Active	1/1/2026	12/31/2026	Washington
David Charles Blood	MD	53010	Active	1/1/2026	12/31/2026	Washington
Laura Morgan	MD	53194	Active	1/21/2026	12/31/2026	Washington
Amit Aime Batra	MD	53304	Active	1/29/2026	12/31/2026	Washington
Ceceleta Yvonne Maitland	MD	53306	Active	1/29/2026	12/31/2026	Wisconsin

*\*Total licenses issued since April 2017 - 6,633*



EXHIBIT

B

STATE of ALABAMA  
**MEDICAL LICENSURE COMMISSION**

**To:** Medical Licensure Commission  
**From:** Nicole Roque  
**Subject:** February Physician Monitoring Report  
**Date:** 2/24/2026

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**The physicians listed below are currently being monitored by the MLC.**

**Richard E. Jones, M.D.**  
**Shakir Raza Meghani, M.D.**  
**Kenneth Eugene Roberts, M.D.**



## Alabama Medical Licensure Commission 2025 Annual Report

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### LICENSURE

<b>Medicine/Osteopathy Licenses Issued</b> .....	<b>3,460</b>
MD .....	2,650
DO .....	508
LL .....	302
RSV .....	2
Temporary Military MD .....	0
Temporary Military DO .....	0
IMLC (MDs –1,513) (DOs – 251) .....	1,764
<b>Medicine/Osteopathy Licenses Renewed</b> .....	<b>22,676</b>
<b>In-State Physician Renewals</b> .....	<b>12,747</b>
<b>Out-of-State Physician Renewals</b> .....	<b>9,929</b>
<b>Reinstatements (Non-Disciplinary)</b> .....	<b>161</b>

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### DISCIPLINARY ACTIONS

<b>Administrative Complaints Filed</b> .....	<b>14</b>
<b>Summary Suspension</b> .....	<b>4</b>
<b>Revocation</b> .....	<b>6</b>
<b>Suspension</b> .....	<b>2</b>
<b>Reprimands</b> .....	<b>2</b>
<b>Administrative Fines Assessed</b> .....	<b>13</b>
<b>Administrative Costs Assessed</b> .....	<b>4</b>
<b>Administrative Complaints Dismissed</b> .....	<b>6</b>
<b>Administrative Complaints Pending from 2024</b> .....	<b>2</b>

<b>Administrative Complaints/ Hearings Carried Over to 2026</b> .....	<b>3</b>
<b>Voluntary Surrender</b> .....	<b>7</b>
<b>Reinstatement Contested by BME</b> .....	<b>2</b>
Reinstatements Denied .....	2
<b>Requests to Lift/Modify MLC Orders</b> .....	<b>14</b>
Requests Granted .....	10
Requests Denied .....	4
<b>Application Filed for Rehearing</b> .....	<b>1</b>
Denied .....	1
<b>Show Cause Hearings for Licensure</b> .....	<b>0</b>
<b>Show Cause Hearings for Non-Compliance</b> .....	<b>0</b>
<b>Appeal to the MLC of BME Decision</b> .....	<b>0</b>
<b>Appeal to Court of Civil Appeals</b> .....	<b>3</b>
MLC Decision Affirmed .....	0
MLC Decision Denied .....	0
Appeal Pending .....	3
<b>Appeal to Alabama Supreme Court</b> .....	<b>0</b>

# Alabama Medical Licensure Commission



## Resolution

RECOGNIZING PAUL M. NAGRODZKI, MD'S EIGHT YEARS OF DISTINGUISHED SERVICE ON THE  
ALABAMA MEDICAL LICENSURE COMMISSION

**WHEREAS**, the Alabama Medical Licensure Commission was created by Act 1981-218 and plays a vital role in the bicameral system created to regulate the practice of medicine and help ensure Alabama patients receive safe, high-quality healthcare; and

**WHEREAS**, Paul Michael Nagrodzki, MD was appointed to serve on the Medical Licensure Commission on April 2, 2018, by Governor Kay Ivey; and

**WHEREAS**, Dr. Nagrodzki earned his medical degree from the University of Alabama School of Medicine, completed his Internal Medicine internship at Birmingham's Baptist Medical Center, and completed his Anesthesia residency at the University of Alabama Hospital and Clinics, where he served as Chief Resident; and

**WHEREAS**, Dr. Nagrodzki's distinguished thirty-four-year career as a respected member of the Brookwood Medical Center's Department of Anesthesia included one year as Medical Director for the Department of Surgery and three years as Chairman of the Department of Anesthesia; and

**WHEREAS**, Dr. Nagrodzki has an equally distinguished record of leadership and service within Alabama's medical community that includes eight years of service on the Alabama Board of Medical Examiners and eight years of service on Alabama's State Committee on Public Health; and

**WHEREAS**, Dr. Nagrodzki has also served on the board of the Alabama Quality Assurance Foundation, including terms as Treasurer, Vice President, and President; and

**WHEREAS**, Dr. Nagrodzki's community involvement includes volunteer service on the Robinson Foundation Board of Directors and support of the Breast Cancer Research Foundation and Magic Moments Foundation; and

**WHEREAS**, Dr. Nagrodzki's thoughtful deliberations and invaluable contributions to the Alabama Medical Licensure Commission, including his service as Vice Chairman and his development of the procedure known as "The Nagrodzki Rule," have helped ensure patient safety and strengthen Alabama's medical licensure standards; therefore, be it

**RESOLVED**, that the Alabama Medical Licensure Commission expresses its sincere appreciation to Dr. Paul M. Nagrodzki for his eight years of service and wishes him good health, happiness, and fulfillment in his well-deserved retirement; and be it further

**RESOLVED**, that a copy of this resolution be presented to Dr. Nagrodzki as a token of the Commission's appreciation and that this resolution be entered into the Commission's official records.

Approved by the Alabama Medical Licensure Commission this 25<sup>th</sup> day of February, 2026



EXHIBIT  
E

STATE of ALABAMA  
MEDICAL LICENSURE COMMISSION

MEMORANDUM

**To:** Medical Licensure Commission  
**From:** Rebecca Robbins  
**Date:** February 18, 2026  
**Subject:** Draft Rule Revisions

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Attached are drafts of preliminary revisions for the following Alabama Administrative Rules for discussion with General Counsel, Aaron Dettling.

*Alabama Administrative Rule 545-X-4-.06: Unprofessional Conduct*

*Alabama Administrative Rule 545-X-4-.10: Registered Mailing Address; Service of Pleadings, Notices And Other Papers*

*Alabama Administrative Rule 545-X-3-.03: Initiation Of A Contest Case; Notice And Opportunity For Hearing In Contested Cases; Contents Of Notice; Procedure Upon Failure Of Notified Party To Appear; Presentation Of Evidence And Argument; Right To Counsel; Disposition By Stipulation; Settlement; Contents Of Record; Public Attendance At Oral Proceedings; Recordings And Transcripts of Oral Proceeding.*

*Alabama Administrative Rule 545-X-3-.08: Appointment And Authority Of Hearing Officer And Legal Counsel; Grounds For Suspension Or Revocation Of License*

## Rule 545-X-4-.06 - Unprofessional Conduct

Unprofessional conduct shall mean the ~~Commission~~ commission or omission of any act that is detrimental or harmful ~~to the patient of the physician or detrimental or harmful to~~ to the health, safety, and welfare of the patient or of the general public, and which violates the high standards of honesty, diligence, prudence, and ethical integrity demanded from physicians and osteopaths licensed to practice in the State of Alabama. ~~Furthermore, w~~Without limiting the definition of unprofessional conduct in any manner, the Commission sets out the below as examples of unprofessional conduct:

(1) The refusal by a physician to comply, within a reasonable time, with a request from another physician for medical records or medical information when such request is accompanied by a properly executed authorization of the patient.

(2) ~~Intentionally, knowingly or willfully~~ Knowingly causing or permitting a false or misleading representation of a material fact to be entered on any medical record of a patient.

(3) ~~Intentionally, knowingly or willfully~~ Knowingly preparing, executing or permitting the preparation by another of a false or misleading report or statement concerning the medical condition or extent of disability of a patient.

(4) ~~The p~~Prescribing, dispensing, administering, supplying or otherwise distributing ~~of any~~ Schedule II amphetamine and/or Schedule II amphetamine-like anorectic drug in violation of ~~Code of Ala. 1975, Ala. Code~~ § 20-2-54, as amended in Act No. 83-890, Special Session, 1983.

(5) ~~The f~~Failure to report to the Alabama State Board of Medical Examiners any final judgment rendered against such physician during the preceding year or any settlement in or out of court during the preceding year, resulting from a claim or action for damages for personal injuries caused by an error, omission, or negligence in the performance of his professional services, or in the performance of medical professional services without consent ~~without consent~~ as required by ~~Code of Ala. 1975, Ala. Code~~ § 34-24-56.

(6) ~~The r~~Refusal or failure by a physician to comply with an order entered by the ~~Medical Licensure Commission or by the Board of Medical Examiners issued pursuant to Code of Ala. 1975, Ala. Code~~ § ~~Section~~ 34-24-360(19) or (20) or ~~pursuant to Code of Ala 1975, Section~~ Ala. Code § 34-24-361(h).

(7) ~~Intentionally or knowingly~~Knowingly making a false, deceptive or misleading statement in any advertisement or commercial solicitation for professional services and/or ~~intentionally or knowingly~~ making a false, deceptive or misleading statement about another physician or group of physicians in any advertisement or commercial solicitation for professional services.

(8) Failure or refusal of a J-1 physician to comply with waiver service requirements stated in the J-1 Visa Waiver Affidavit and Agreement signed by a J-1 physician.

(9) Conduct which is immoral ~~and which is willful~~, shameful, and which ~~shows a moral~~ evidences indifference to the moral standards and opinions of the community.

(10) Conduct which is dishonorable and ~~which shows~~ evidences a disposition to lie, cheat, or defraud.

(11) Failing or refusing to maintain adequate medical records on a patient or patients.

(12) Prescribing or dispensing a controlled substance to oneself or to one's spouse, child, sibling (including step- and half-siblings), parent, intimate partner, or to any other person where the physician's professional objectivity, the patient's autonomy, or informed consent are substantially compromised, unless such prescribing or dispensing is necessitated by emergency or other exceptional circumstances.

(13) Signing a blank, undated or predated prescription form.

(14) Representing that a manifestly incurable disease or infirmity can be ~~permanently~~ cured, or that any disease, ailment or infirmity can be cured by a secret method, procedure, treatment, medicine or device, if such is not the fact.

(15) Refusing to divulge to the ~~board~~ Board or ~~commission~~ Commission upon demand the means, method, procedure, modality of treatment, or medicine used in the treatment of a disease, injury, ailment or infirmity.

(16) Knowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or osteopathy or in applying for privileges or renewing an application for privileges at a health care institution.

(17) Sexual misconduct in the practice of medicine as defined in Rule 545-X-4-.07.

(18) Representing or holding oneself out as a medical specialist when such is not the case.

(19) Failing to furnish information in a timely manner to the ~~board~~ Board or Commission if requested by the ~~board~~ Board or Commission.

(20) Failing to report to the ~~board~~ Board in a timely manner information required to be reported by ~~Code of Ala. 1975, Section~~ Ala. Code § 34-24-361(b).

~~(21) Giving false testimony in any judicial or administrative proceeding.~~

~~(22) The~~ Violation of any rule duly promulgated by the Alabama Board of Medical Examiners or the Medical Licensure Commission pursuant to their rule making authority as set forth in the Alabama Administrative Procedures Act.

~~(23) The~~ Refusal or failure by a physician to comply with any voluntary agreement entered into between the physician and the Board of Medical Examiners and/or the Commission.

(23) Acts detrimental to the proper regulation of the practice of medicine, including but not limited to:

(a) Knowingly making a false statement of material fact in any investigation or contested case proceeding conducted by the Board, any contested case proceeding conducted before the Commission, or in any other formal judicial or administrative proceeding relating to the practice of medicine.

(b) Knowingly falsifying, altering, or destroying any document, record, or other evidence when the physician has reason to believe that such document, record, or evidence may be relevant to an investigation or proceeding before the Board or Commission.

(c) Harassing or intimidating conduct, the intended or reasonably foreseeable result of which is to coerce, obstruct, or otherwise interfere with any person's participation in an investigation or proceeding before the Board or Commission, or to retaliate against any person for participating in an investigation or proceeding before the Board or Commission.

(d) Submitting any motion, pleading, brief, or other paper to the Board or to the Commission containing false, fabricated, or nonexistent legal citations. This subdivision applies to all physicians, whether or not represented by a licensed attorney.

Author: ~~Wayne P. Turner, Wallace D. Mills~~ Medical Licensure Commission of Alabama

Statutory Authority: ~~Code of Ala. 1975,~~ Ala. Code § 34-24-360(2).

History: Filed February 3, 1984. Amended: Filed June 4, 1985. Amended: Filed July 11, 2000; effective August 15, 2000. Amended: Filed March 4, 2003; effective April 8, 2003. Amended: Filed June 24, 2005; effective July 27, 2005. Amended: Filed December 10, 2018; effective January 24, 2019. Amended: Published July 31, 2024; effective September 14, 2024.

**SOURCE MATERIALS CONSULTED; NOT PART OF THE RULE**

3. Failing to Cooperate with the Board--physicians shall cooperate with and assist the board to carry out its duties. A physician shall, among other matters:

a. respond or provide information or items requested, respond to a subpoena, or complete an evaluation within the time designated by the board or its staff;

b. not attempt to influence the board, its members, staff or agents by means of intimidation, falsehoods or other means prohibited by law;

c. not contact members of the board directly or through others in an attempt to influence the outcome of an investigation or disciplinary proceeding; and

d. not contact or attempt to contact a complainant or witness regarding a complaint or an investigation by the board for purposes of intimidation or harassment;

46 La. Admin. Code Pt XLV, 7603

(p) Failing to cooperate with the Board during an investigation of a complaint filed under the provisions set out in Rule 746-X-4 by not furnishing required documentation or responding to a request for information or a subpoena issued by the Board or its authorized representative;

(q) Interfering with an investigation or disciplinary proceeding by willful misrepresentation of facts or by use of threats, retaliation, or harassment against anyone;

Ala. Admin. Code 746-X-3-.04

(24) failing to cooperate with an official investigation by the board or the board's representatives, including failing to timely provide requested information;

(25) failing to allow the board or the board's representative, upon written request, to examine and have access to records maintained by the licensee that relate to the licensee's practice under AS 08.64;

Alaska Admin. Code tit. 12, § 40.967

(13) Falsifying, altering or destroying treatment records in contemplation of an investigation by the Board or a lawsuit being filed by a patient.

(14) Intentionally presenting false or misleading testimony, statements, or records to the Board or the Board's investigator or employees during the scope of any investigation, or at any hearing of the Board.

(15) Conspiring with any person to commit an act, or committing an act which would tend to coerce, intimidate, or preclude any patient or witness from testifying against a licensee in any disciplinary hearing, or retaliating in any manner against any patient or other person who testifies or cooperates with the Department of Health during any investigation involving the Board.

Tenn. Comp. R. & Regs. 0460-01-.12

2) presenting false or misleading testimony, statements, omissions, or records in any communication to the Board or the Board's investigators, employees, or agents regarding any matter subject to the provisions of the Dental Practice Act or Dental Hygiene Act;

\* \* \*

(5) conspiring with any person to commit an act, or committing an act that would coerce, intimidate, or preclude any patient or witness from testifying against a licensee in any disciplinary hearing, or retaliating in any manner against any patient or other person who testifies or cooperates with the Board during any investigation under the Dental Practice or Dental Hygiene Acts;

\* \* \*

(14) failing to submit a truthful response to a notice of complaint filed against the licensee with the Board, or to any related request, accompanied by a signed verification on a form provided by the Board with the notice or request, within the time allowed by the Board;

(15) failing to notify the Board of a change in current primary physical address, which shall be either a personal address or a business address at the licensee's election, within 10 business days;

21 N.C. Admin. Code 16V.0101

(5) Cooperation. Failure by respondent to cooperate with a board investigation constitutes unprofessional conduct per ORS 675.070(2), and is grounds for disciplinary action.

(a) Cooperation by respondent includes:

(A) Submitting client records to the Board's investigator, with or without a signed release by the client, for a full investigation of the allegations presented in the notice letter;

(B) Sending a complete case file to the Board's investigator;

(C) Being available for a personal interview with the Board's investigator; and

(D) Responding truthfully and accurately to all questions presented by the Board's investigator.

(b) To cooperate with an investigation, respondents may not:

(A) Use threats or harassment to delay or obstruct any person in providing evidence in any investigation, contested case, or other legal action instituted by the Board;

(B) Use threats or harassment to obstruct or delay the Board in carrying out its regulatory functions;

(C) Deceive or attempt to deceive the Board with respect to any matter under investigation including altering or destroying any records;

(D) Attempt to influence the testimony or participation in an investigation of any person believed to be a complainant or witness in a Board investigation, or to permit or encourage another person to do so; or

(E) Engage in retaliation against another person for their participation in a Board investigation or provision of information to the Board.

Or. Admin. R. 858-020-0045 (833-110-0011 substantially the same)

(v) Fails to cooperate with the Board, which includes but is not limited to the following:

(A) Failure to respond fully and truthfully to a question or request for information from the Board;

(B) Failure to provide information or documents to the Board within the time specified by the Board;

(C) Failure to appear and provide information at an interview requested by the Board;

(D) Failure to timely produce and temporarily surrender custody of an original patient record requested by the Board and which is in the possession or under the control of the licensee, or failure to produce all portions of the patient record requested;

(E) Deceiving or attempting to deceive the Board regarding any matter, including by altering or destroying any record or document; or

(F) Failure to comply with the terms, conditions and recommendations of a Confidential Advisory Letter as issued by the Board;

(w) Interferes with or uses threats or harassment to delay or obstruct any person in providing information or evidence to the Board in any matter, investigation, contested case proceeding or other legal action instituted by the Board;

(x) Discharges an employee based primarily on the employee's attempt to comply or aid in the compliance with Board rules;

Or. Admin. R. 848-045-0020

(m) interference with an audit, investigation, inspection, or disciplinary proceeding by failure to respond or cooperate, willful misrepresentation of facts, use of threats or harassment against or inducement to a client or witness to prevent them from providing evidence in a disciplinary proceeding or other legal action or use of threats or harassment against or inducement to a person to prevent or attempt to prevent a disciplinary proceeding or other legal action from being filed, prosecuted, or completed;

Mont. Code Ann. § 37-1-410 (West)

**545-X-4-10. Registered Mailing Address; Service Of Pleadings, Notices And Other Papers.**

(1) Every physician licensed to practice medicine and/or osteopathy in the State of Alabama has a continuing affirmative obligation to maintain a current mailing address with the Commission. If any physician shall change his or her address during the year for which any certificate of registration shall have been issued by the Commission, such physician shall, within 15 days thereafter, notify the Commission of such change, whereupon the Commission shall issue to such physician, without additional fee, a duplicate registration certificate for such new location.

(2) Unless provided for elsewhere in these rules, service of pleadings, notices, and other papers by the Commission, parties, or interested persons may be affected by one of the following methods. Any notice, pleading, or other document required by law to be served by the Commission upon a physician may be served by any one or more of the following methods:

(a) by service in accordance with the Alabama Rules of Civil Procedure by personal service effected by a Board investigator;

(b) by placing notice in the U.S. Certified Mail, with return receipt requested, properly addressed with necessary postage affixed to the physician at an address provided by the physician pursuant to subsection (1) of this Rule, which service shall be deemed perfected upon mailing;

(c) by third-party commercial carrier for delivery within three calendar days with delivery receipt required addressed to the physician at an address provided by the physician pursuant to subsection (1) of this Rule, in which case service is shall be deemed perfected upon delivery deposit with the carrier;

(d) by electronic mail upon agreement of the recipient to accept service by electronic mail, which service shall be deemed perfected upon receipt by the sender of an electronic mail acknowledging or showing receipt by the person upon whom service was intended.

(2) Where an appearance has been entered by an attorney on behalf of a party or interested person, service under this rule may be made upon said attorney.

Author: Wallace D. Mills

**Credits**

**Statutory Authority: Code of Ala. 1975, §§ 41-22-12(a), 34-24-337, 34-24-338.**

**History: New Rule: Filed December 10, 2018; effective January 24, 2019.**

**545-X-3-.03. Initiation Of A Contested Case; Notice And Opportunity For Hearing In Contested Cases; Contents Of Notice; Procedure Upon Failure Of Notified Party To Appear; Presentation Of Evidence And Argument; Right To Counsel; Disposition By Stipulation; Settlement; Contents Of Record; Public Attendance At Oral Proceedings; Recordings And Transcripts Of Oral Proceedings.**

(1) A contested case before the Medical Licensure Commission shall be initiated by the filing of a written administrative complaint signed by any member of the Alabama Board of Medical Examiners, any duly licensed physician, the executive officer of the Board, or any other person, and which alleges that the respondent may be guilty of one or more of the grounds for discipline of a license to practice medicine as provided in ~~Code of Ala. 1975,~~ Ala. Code § 34-24-360, and these rules and regulations.

(2) Any physician holding a certificate of qualification to practice medicine in Alabama shall and is hereby required to, and any other person may, report to the Board or the Commission any information such physician or other person may have which appears to show that any physician holding a certificate of qualification to practice medicine in Alabama may be guilty of any of the acts, offenses or conditions set out in ~~Code of Ala. 1975,~~ Ala. Code § 34-24-360; and any physician or other person who in good faith, makes such a report to the Board or to the Commission shall not be liable to any person for any statement or opinion made in such report.

(3) In a contested case for the discipline of a license instituted by the filing of an administrative complaint, all parties shall be afforded an opportunity for hearing after reasonable notice in writing. Such notice shall be delivered to the physician against whom the administrative complaint is filed ~~by personal service required by § 34-24-361(e) as prescribed in Rule 545-X-4-.10.~~ Delivery of the notice referred to in this subsection shall constitute commencement of the contested case proceedings.

(4) The notice shall include:

- (a) A statement of the time, place and nature of the hearing;
- (b) A statement of the legal authority and jurisdiction under which the hearing is to be heard;
- (c) A reference to the particular sections of the statutes and rules involved.

(5) In addition, the notice may include:

(a) A time deadline for the filing of an answer to the administrative complaint;

(b) A time deadline for the filing of all motions addressed to the sufficiency of the administrative complaint;

(c) A time deadline for the filing of all motions requesting prehearing relief;

(d) A time deadline for the complainant to furnish to the respondent a list of witnesses who are expected to offer testimony;

(e) A time deadline for the respondent to furnish to the complainant a list of witnesses who are expected to offer testimony;

(f) A time deadline for the complainant and the respondent to furnish to the Commission the name and full address of each witness residing in the State of Alabama who is requested to be subpoenaed for attendance at the hearing;

(g) A copy of the administrative complaint that has been filed before the ~~Medical Licensure~~ Commission in regard to the license of the physician and which contains a short and plain statement of the matters asserted. If the complainant is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved. Thereafter, upon application, a more definite and detailed statement shall be furnished.

(6) Upon receipt of the Notice of Hearing by the respondent, the respondent shall file an answer with the Commission which either admits or denies the allegations contained in the administrative complaint which was filed against the respondent before the ~~Medical Licensure~~ Commission. If the respondent fails to file an answer, a general denial shall be entered on behalf of the respondent and the allegations in the administrative complaint shall be deemed denied.

(a) If the respondent admits the allegations of the administrative complaint and those admissions indicate that the respondent is guilty of a violation of ~~Code of Ala. 1975~~, Ala. Code § 34-24-360, then the hearing scheduled by the ~~Medical Licensure~~ Commission shall proceed on the question of appropriate punishment for the violation. At this hearing, all parties shall be afforded the opportunity to present evidence which is germane to the issue of appropriate punishment.

(b) If the answer filed by the respondent denies the allegations of the administrative complaint filed with the ~~Medical Licensure~~ Commission, then the hearing scheduled by the Commission shall proceed on the factual matters which are alleged in the administrative complaint.

(c) If the respondent fails to file an answer, or if the respondent files an answer and such answer does not specifically place in issue proper service of the initial notice described in subsection (3) of this Rule, then proper service of the initial notice described in subsection (3) of this Rule shall be deemed admitted.

(7) If a party fails to appear, or absents himself, in a contested case proceeding after proper service of notice, the presiding officer may, if no adjournment is granted, proceed with the hearing and make a decision in the absence of the party.

(8) Opportunity shall be afforded all parties to respond and present evidence and argument on all material issues involved and to be represented by counsel at their own expense.

(9) Unless precluded by statute, informal dispositions may be made of any contested case by stipulation, agreed settlement, consent order or default or by another method agreed upon by the parties in writing, subject to approval of the Commission.

(10) The record in a contested case shall include:

(a) All pleadings, motions, and intermediate rulings;

(b) All evidence received or considered and all other submissions; provided, in the event that evidence in any proceeding may contain proprietary and confidential information, steps shall be taken to prevent public disclosure of that information;

(c) A statement of all matters officially noticed;

(d) All questions and offers of proof, objections and rulings thereon;

(e) All proposed findings and exceptions;

(f) Any opinion or report by the legal counsel at the hearing; and

(g) All staff memoranda or data submitted to the legal counsel or members of the agency in connection with their consideration of the case

unless such memoranda or data is protected as confidential or is recognized as privileged by laws of the state of Alabama; provided, if such memoranda or data contains information of a proprietary and confidential nature, it shall be protected by the Commission from public disclosure.

(h) Administrative complaints seeking to discipline the licenses to practice medicine of physicians and all orders of the Commission which are dispositive of the issues raised by such complaints shall be public record.

(11) Hearings on administrative complaints shall be closed. The record in such hearings, including witness testimony, exhibits and pleadings, shall be confidential and shall not be available for public inspection; provided, however, that all administrative complaints, and amendments thereto, and all orders of the Commission which are dispositive of the issues raised by such complaints, shall be public record.

(12) Oral proceedings shall be recorded either by mechanized means or by qualified shorthand reporters. Oral proceedings or any part thereof shall be transcribed at the request of any party with the expense of the transcription charged to the requesting party. The recording of stenographic notes of oral proceedings or the transcription thereof shall be filed with and maintained by the agency for at least five years from the date of decision and shall be made available for inspection by the public, except in those cases where hearings are closed, or where the proceedings shall be ordered sealed by order of court, or are required to be sealed by statute.

(13) An administrative complaint may be amended without leave of the Commission at any time more than 45 days before the first setting of the case for hearing. Thereafter, the Commission may permit the administrative complaint to be amended, but no amendments shall be permitted that are not germane to the acts, offenses or conditions originally charged or that materially alters the nature of any act, offense or condition charges; provided, however, that amendments to conform to the evidence may be allowed in conformance with Rule 15(b), Alabama Rules of Civil Procedure.

(14) Findings of fact shall be based solely on the evidence in the record and on matter officially noticed in the record.

(15) The Commission shall not order the suspension or revocation of a license unless at least five members of the Commission are present and a majority of those present vote for such suspension or revocation.

(16) The final order of the Commission shall be served upon the respondent as prescribed in Rule 545-X-4-.10.

Author: Wayne P. Turner, Wallace D. Mills

Credits

Statutory Authority: Code of Ala. 1975, §§ 34-24-361, 34-24-361.1, 34-24-366, 34-24-337, 34-24-338, 41-22-12.

History: Filed May 6, 1983. Repealed and new rule adopted in lieu thereof: Filed May 1, 1984. Amended: Filed March 4, 2003; effective April 8, 2003. Amended: Filed May 5, 2010; effective June 9, 2010. Amended: Filed December 10, 2018; effective January 24, 2019.

**Rule 545-X-3-.08 - Appointment And Authority Of Hearing Officer And  
Legal Counsel; Grounds For Suspension Or Revocation Of License**

(1) The Commission may appoint, from time to time, a hearing officer for the purposes of presiding over and conducting contested case hearings before the Commission and issuing pre-hearing rulings as may be necessary to the orderly conduct of said cases. The hearing officer shall be an attorney licensed to practice law in the state of Alabama. The Commission's hearing officer shall not have participated in the investigation or prosecution of the licensee in the matters pertaining to the contested case. The hearing officer shall not have a manifest conflict of interest with any party in a contested case. The general duties of the hearing officer shall be to preside over and direct the course of contested cases before the Commission, Specifically, the hearing officer is empowered to:

(a) Issue procedural orders setting dates, deadlines, and timetables by which parties must submit or disclose evidentiary material or notices related to the orderly conduct of a contested case. Hearing dates shall be set by the Chairman. The hearing officer may grant continuances or postponements of hearings on contested cases upon the assent of the Chairman.

(b) To issue subpoenas, protective orders, and discovery orders on behalf of the Commission upon application of a party. The hearing officer may impose reasonable conditions and limitations on discovery in a contested case through limited written interrogatories, document production, and depositions as may be allowed by the Alabama Administrative Procedures Act.

(c) To impose reasonable conditions and limitations on the parties' presentations during a contested case including, but not limited to: the prescribing of reasonable limitations on argument, prescribing the length of time allotted for the presentation of a parties' case, directing that evidence relevant to the general character and reputation of the licensee be submitted in writing by affidavit or to place reasonable limitations upon the number of witnesses permitted to testify as to the character and reputation of the licensee, and/or requiring the parties to submit briefs or memoranda on issues put before the Commission.

(d) To issue orders and rulings related to the attendance of parties, attorneys, and witnesses at hearings and conferences.

(e) To hold and preside over pre-hearing conferences of parties and/or attorneys as may be necessary to the orderly conduct of a contested case.

(f) To issue orders and rulings on all other matters of procedure and law necessary to the orderly conduct of the contested case. In ruling on motions or objections contesting the legal sufficiency of an administrative complaint or notice given under the Alabama Administrative Procedures Act, the hearing officer may order the complainant to file a more definite statement. Dismissal of a complaint will only be upon the order of the Commission.

(g) To administer oaths and to certify the authenticity of documents when required in the discharge of their duties as hearing officer in a contested case.

(2) Legal counsel is an individual appointed by the Commission to act in such capacities and with such authority as is specified herein. Legal counsel shall be an attorney licensed to practice law in the state of Alabama. The legal counsel shall be compensated at a rate to be prescribed by the Commission for services actually performed pursuant to a contractual agreement. Subject to the restrictions concerning participation in prosecution and conflict of interest, a legal counsel may be an employee of the Commission. The general duties of the legal counsel shall be to advise the Commission on matters of law and evidence pertaining to contested cases and issues before the Commission and to assist the Commission in the preparation of orders, communications, opinions, and decrees.

(a) The legal counsel is specifically authorized to represent the Commission in all matters involving the Commission in state and federal courts. The legal counsel is specifically authorized to represent the Commission in all appeals from its decisions and orders.

(b) The legal counsel shall advise the Commission on matters of evidence and law during its deliberations.

(c) When directed by the Commission, the legal counsel shall prepare the final order reflecting the decision of the Commission in each contested case. The final order shall be executed and authenticated in the manner prescribed by the Commission.

(d) The legal counsel shall draft and advise the Commission on rules changes as directed by the Commission.

(e) In addition, the legal counsel shall be authorized to perform such duties and functions as may be prescribed by the Commission, it being the intent of this rule that the legal counsel shall be the chief legal advisor to the Commission. The Commission's legal counsel shall not have participated in the investigation or prosecution of the licensee in the matters pertaining to the contested case. The legal counsel shall not have a manifest conflict of interest with any party in a contested case.

(3) Where no hearing officer is appointed by the Commission, the Chairman of the Commission shall preside during hearings with the assistance and advice of legal counsel and perform all other duties of the hearing officer.

(4) Except as provided otherwise in Ala. Code § 34-24-366 and Rule 545-X-3-.14(3), All evidence and argument shall be presented before the Commission, and no member of the Commission shall participate in the final decision unless he the member either has been present during all of the hearing or unless he has reviewed and considered the complete record of those proceedings ~~which took place in his absence.~~

(5) All rulings of the hearing officer or Chairman, where no hearing officer is appointed, or the Chairman's designee shall be final and shall be deemed to be the action of the Commission unless such rulings are challenged by a member of the Commission. All such challenges are to be considered and decided by the Commission outside the presence of the parties, attorneys and witnesses to the contested case, and only the decision of the Commission shall be entered into the record. The Chairman is specifically authorized to require that any person whose behavior is disruptive to the orderly conduct of the proceedings leave the hearing and may then order the proceedings to continue or to be postponed as circumstances shall dictate.

(6) During the conduct of any contested case the members of the Commission may direct questions to witnesses who testify before the Commission.

(7) The hearing shall be conducted in so far as is practicable in the same manner as a civil action at law. In a hearing the complainant shall have the obligation to proceed first and to present such evidence touching upon the specific allegations of the complaint as will establish at least a prima facie violation of the offenses and conditions as stated in the complaint. At the conclusion of the complainant's presentation, the ~~respondent~~ Respondent shall have the opportunity to call witnesses on his or her behalf and to rebut the allegations of the complainant and/or to present evidence in mitigation of the evidence presented by the complainant. At the

completion of Respondent's case, Complainant shall be allowed to call witnesses or submit evidence to rebut facts or issues raised by Respondent.

(8) At the conclusion of the hearing, the Commission shall hold its deliberations in ~~executive session~~ closed session pursuant to Ala. Code § 34-24-361.1 in consultation with the legal counsel. If the Commission finds that a physician is guilty of any of the acts, offenses or conditions enumerated in § 34-24-360, the Commission may take any of the following actions or any combination of the following actions:

(a) Enter a judgment and impose a penalty, which penalty may include revoking, suspending, or restricting a license to practice medicine, issuing a reprimand, issuing a non-disciplinary citation, imposing a fine, or any combination thereof;

(b) Suspend imposition of judgment and penalty;

(c) Impose judgment and penalty, but suspend enforcement thereof by placing the physician on probation, which probation shall be revocable if the Commission finds that the conditions of the probation order are not followed by the physician.

(i) As a condition of probation the Commission may require the physician to submit to care, counseling, or treatment by a healthcare professional designated by the Commission. The expense of such care, counseling or treatment shall be borne by the physician on probation.

(ii) The Commission may at any time modify the conditions of the probation and may include among them any reasonable condition for the purpose of the protection of the public or for the purpose of the rehabilitation of the probationer or both.

(d) Impose a fine on the ~~respondent~~ Respondent in an amount not greater than ten thousand dollars (\$10,000.00) for each violation of § 34-24-360 or any rule or regulation of the Commission which relates to Ala. Code § 34-24-360.

(i) All administrative fines assessed by the Commission shall be due and payable to the Commission within thirty (30) days from the date the fine is assessed, unless otherwise provided for by order of the Commission. In the event that an appeal is filed subject to Ala. Code § 34-24-357~~367~~, ~~Code of Ala. 1975~~, then the fine shall be required to

be paid. However, the Commission shall refund the fine in the event the decision of the Commission is reversed by the final judgment of the reviewing court.

(ii) The Commission shall not renew the annual certificate of registration as set forth in ~~Section Ala. Code § 34-24-337~~ of any physician against whom an administrative fine has been assessed by the Board of Medical Examiners or the Commission until such fine is paid in full. However, if an order of the Medical Licensure Commission or the Board of Medical Examiners allows for the payment of the fine or costs in installments and if the licensee is current with the installment payment, then the physician shall be permitted to renew his or her certificate of registration. In the event that the fine is paid more than thirty-one (31) days after registration is due, the licensee shall be required to pay the reinstatement fee and complete all forms as provided by these rules.

(iii) All administrative fines received by the Commission shall be deposited in an escrow account and held until all proceedings seeking review of the Commission's order have concluded. At the conclusion of these proceedings or after the statutory period for filing an appeal has lapsed, all fines paid to the Commission shall be deposited with the Board of Medical Examiners for use as provided by statute and by the rules and regulations of the Alabama State Board of Medical Examiners.

(9) Administrative Costs: in addition to the administrative fine authorized in subsection (8)(d), the Commission, upon application by the Board of Medical Examiners, may require a physician found to be in violation of ~~Section Ala. Code § 34-24-360~~ to pay the costs, fees, and expenses of the Board incurred in connection with any proceedings before the Commission. Such costs include, but are not limited to the following:

- (a) The actual cost of independent medical review and expert testimony.
- (b) Fees and expenses of ~~board~~ Board counsel.
- (c) Deposition costs.
- (d) Travel expenses for ~~board~~ Board staff.

(e) Charges incurred for obtaining documentary evidence, and such other categories of expenses as may be prescribed in regulation published by the Board and Commission.

(f) To recover administrative costs and expenses associated with excessive and unnecessary filings, an assessment equal to \$0.50 per word of any motions, pleadings, or other papers filed by the Respondent with the Commission, excluding the following:

(i) One Answer to the Administrative Complaint;

(ii) One motion, not exceeding 2,000 words, testing the legal and/or factual sufficiency of the allegations of the Administrative Complaint;

(iii) Any motion, pleading, or other paper directed or authorized in advance by the Hearing Officer;

(iv) Any motion, pleading, or other paper, or the portion thereof, which results in the Commission granting substantial relief to the Respondent;

(v) Witness and exhibit lists;

(vi) Exhibits filed as documentary evidence, and sworn testimony given, in the contested case hearing; and

(vii) One application for rehearing pursuant to Ala. Code § 41-22-17.

(10) Payment of any costs, fees, or expenses ordered by the Commission shall be made and enforced in the same manner as an administrative fine, as set forth in the preceding section. The following procedures shall be followed with the regard to requests for costs, fees and expenses:

(a) If the Board intends to seek the imposition of costs, fees and expenses, it shall give notice of such intent prior to the commencement of the final hearing. Such notice may be included in the Administrative Complaint, or it may be given by separate pleading filed with the Commission, a copy of which shall be served on the licensee or his/her attorney.

(b) Unless otherwise ordered by the Commission, the Board shall submit to the Commission, within thirty days after the conclusion of the final hearing, a complete bill of costs, fees and expenses. Such bill of costs, fees and expenses shall include a verification by the General Counsel of the Alabama Board of Medical Examiners, that the costs, fees, and expenses were necessary for the prosecution of the case. A copy of such bill of costs, fees and expenses shall be served upon the licensee or his/her attorney.

(c) The licensee may file written objections to the bill of costs, fees and expenses within ten days of service thereof. Such objection shall be set forth in detail the basis for such objection. If no objection is filed, the Commission may assume that the costs, fees and expenses requested are necessary and reasonable.

(d) In determining whether or not to award costs, fees and expenses, the Commission shall determine whether or not such costs, fees and expenses are reasonable and necessary for the prosecution of the case. Attorney fees shall be awarded at a rate not to exceed ~~\$150~~195.00 per hour for the Board's in-house counsel. Attorney fees for outside counsel shall be awarded at a rate not to exceed the contract rate set out in the contract between the Board and said counsel.

(e) The Commission may include its ruling on the request for costs, fees and expenses in its final order. In the alternative, the Commission may enter a final order and reserve for a later time the issue of costs, fees and expenses. The fact that the issue of costs, fees and expenses is reserved for a later ruling shall not affect the finality of the order.

(11) If a license to practice medicine in Alabama is suspended or revoked, the holder of that license shall not practice in Alabama during the term of the suspension or revocation.

(12) If the Commission finds that the physician is not guilty of any of the acts, offenses or conditions enumerated in § 34-24-360, it shall issue a judgment setting out such findings and dismiss the administrative complaint.

(13) When the issue is whether or not a doctor is competent or physically or mentally capable of practicing medicine with reasonable skill and safety to patients, then, upon a showing of probable cause to the Commission that the doctor is not competent or capable of practicing medicine with reasonable skill and safety to patients, the Commission may order and direct the doctor in question to submit to

physical, mental, laboratory, or diagnostic examination or testing or any combination of such examinations or testing to be performed by a physician or other healthcare professional designated by the Commission. The expense of such examination shall be borne by the physician who is so examined.

(14) Every physician licensed to practice medicine in Alabama who accepts the privilege of practicing medicine in Alabama by actually practicing or by the making and filing of an annual registration to practice medicine shall be deemed to have given his consent to submit to a mental, physical or laboratory examination or to any combination of such examination and to waive all objections to the admissibility of the examining health care professional's testimony or examination reports on the ground that they constitute privileged doctor-patient communications.

(15) The Commission shall have the power and duty to suspend, revoke or restrict any license to practice medicine in the State of Alabama or place on probation or fine any licensee, whenever the licensee shall be found guilty on the basis of substantial evidence of any of the following acts or offenses:

(a) Fraud in applying for or procuring a certificate of qualification to practice medicine or a license to practice medicine in this State;

(b) Unprofessional conduct as defined by statute or by these rules and regulations promulgated by the Commission;

(c) Practicing medicine in such a manner as to endanger the health of the patients of the practitioner;

(d) Conviction of a felony; a copy of the record of conviction, certified to by the clerk of the court entering the conviction, shall be conclusive evidence;

(e) Conviction of any crime or offense which reflects the inability of the practitioner to practice medicine with due regard for the health or safety of his patients; a copy of the record of conviction, certified to by the clerk of the court entering the conviction, shall be conclusive evidence;

(f) Conviction for any violation of a federal or state law relating to controlled substances; a copy of the record of conviction, certified to by the clerk of the court entering the conviction, shall be conclusive evidence;

(g) Use of any untruthful or deceptive or improbable statement concerning the licensee's qualifications or effects or results of his proposed treatment;

(h) Distribution by prescribing, dispensing, furnishing, or supplying of controlled substances to any person or patient for any reason other than a legitimate medical purpose;

(i) Gross malpractice or repeated malpractice or gross negligence in the practice of medicine;

(j) Division of fees or agreement to split or divide the fees received for professional services with any person for bringing or referring a patient;

(k) Performance of unnecessary diagnostic tests or medical or surgical services;

(l) Charging fees determined by the Commission to be grossly excessive or intentionally filing or causing to be filed false or fraudulent claims, as defined by the Commission, for medical or surgical services to any private or government third party payor having a legal or contractual obligation to pay such claims on behalf of a patient;

(m) Aiding or abetting the practice of medicine by any person not licensed by the Commission;

(n) Conviction of fraud in filing Medicare or Medicaid claims or conviction of fraud in filing claims to any third-party payor; a copy of the record of conviction, certified to by the clerk of the court entering the conviction, shall be conclusive evidence;

(o) Any disciplinary action taken by another state against a license to practice medicine, based upon acts by the licensee similar to acts described in this section; a certified copy of the record of the disciplinary action of the state making such an action is conclusive evidence thereof;

(p) Refusal to appear before the Board of Medical Examiners after having been formally requested to do so in writing by the Executive Director of the Board;

(q) Making any fraudulent or untrue statement to the Commission or to the Board of Medical Examiners;

(r) The termination, revocation, probation, restriction, denial, failure to renew, suspension, reduction or resignation of staff privileges of a licensee by a hospital in this or any other state when such action is related to negligence or incompetence in the practice of medicine, moral turpitude, sexual misconduct, abusive or disruptive behavior, or drug or alcohol abuse;

(s) Being unable to practice medicine with reasonable skill and safety to patients by reason of illness, inebriation, excessive use of drugs, narcotics, alcohol, chemicals or any other substance, or as a result of any mental or physical condition.

(i) When the issue is whether or not a doctor is competent or physically or mentally capable of practicing medicine with reasonable skill and safety to patients, then, upon a showing of probable cause to the Commission that the doctor is not competent or capable of practicing medicine with reasonable skill and safety to patients, the Commission may order and direct the doctor in question to submit to physical, mental, laboratory, or diagnostic examination or testing, or any combination of such examinations or testing, to be performed by a physician or other healthcare professional designated by the Commission or by the Board of Medical Examiners. The expense of such examination shall be borne by the physician who is so examined.

(ii) Every physician licensed to practice medicine in the State of Alabama who accepts the privilege of practicing medicine in Alabama by actually practicing or by the making and filing of an annual registration to practice medicine shall be deemed to have given his or her consent to submit to a mental, physical, laboratory, or diagnostic examination or testing, or to any combination of such examinations or testing, and to waive all objections to the admissibility of the examining physician's or healthcare professional's testimony, examination reports, or diagnostic reports on the ground that they constitute privileged doctor-patient communications.

(iii) Upon certification by the Board of Medical Examiners that a physician has failed to comply with an order of the Board of Medical Examiners issued pursuant to ~~Code of Ala. 1975, Section Ala. Code~~ § 34-24-360(19)(d) the Commission shall summarily suspend such physician's license. Such suspension shall continue in effect until such time as the physician complies with the order of the Board or the order

is withdrawn by the Board or the order is terminated by the Commission after a hearing.

(iv) All reports, records, and documents obtained by the Board pursuant to an order authorized by ~~section Ala. Code § 34-24-360(19)(d)~~ and introduced as evidence in any hearing conducted by the Commission are privileged and confidential and shall not be public records nor available for court subpoena or for discovery proceedings.

(v) A physician whose license to practice medicine has been suspended by the Commission under the authority of subparagraph (iii) above may obtain judicial review in accordance with the provisions of Sections 41-22-20 and 34-24-367.

(t) Being unable to practice medicine with reasonable skill and safety to patients by reason of a demonstrated lack of basic medical knowledge or clinical competency.

(i) Upon certification by the Board of Medical Examiners that a physician has failed to comply with an order of the Board of Medical Examiners issued pursuant to ~~Code of Ala. 1975, Section Ala. Code § 34-24-360(20)(a)~~ the Commission shall summarily suspend such physician's license. Such suspension shall continue in effect until such time as such physician complies with the order of the Board or the order is withdrawn by the Board or the order is terminated by the Commission after a hearing.

(ii) A physician whose license to practice medicine has been summarily suspended under the authority of subparagraph ~~2-(15)(t)(i)~~ above may obtain judicial review in accordance with the provisions of Sections 41-22-20 and 34-24-367.

(iii) Any physician whose certificate of qualification and license to practice medicine has been restricted by the Board of Medical Examiners under the authority of ~~Code of Ala. 1975, Section Ala. Code § 34-24-360(20)(e)~~ may request a hearing before the Commission. At such hearing it shall be the burden of the Board to demonstrate to the reasonable satisfaction of the Commission that the restriction or restrictions are consistent with the findings of the examination or evaluation ordered by the Board pursuant to ~~Code of Ala. 1975, Section Ala. Code § 34-24-360(20)(b)~~. All such hearings shall be conducted on

an expedited basis and any restrictions ordered by the Board shall not be stayed by the Commission during the pendency of the hearing. The Commission may consider, in any hearing resulting from a decision of the Board to impose a restriction or restrictions on the certificate of qualification and license to practice medicine of the physician in question, the results of all examinations or evaluations of basic knowledge or clinical competency upon which the Board relied and such other evidence as the Commission deems relevant to the issues presented. In rendering a decision, the Commission is authorized to affirm the restriction or restrictions, to modify the restriction or restrictions, or to order the removal of the restriction or restrictions.

(iv) A physician adversely affected by a decision of the Commission resulting from a hearing under the preceding subparagraph (15)(t)(iii) may obtain judicial review in accordance with the provisions of Sections 41-22-20 and 34-24-367.

(v) The Commission may, within its discretion, revoke or suspend the license to practice medicine of a physician who fails to abide by or who violates a restriction or restrictions imposed by the Board, or as modified by the Commission, on the certificate of qualification and license to practice medicine of the physician in question, or it may impose administrative fines or other penalties as authorized by Sections 34-24-361 and 34-24-381.

(u) Excessive prescribing, dispensing, furnishing or supplying of a ~~schedule~~ Schedule II controlled substance. A physician violates this section if he or she prescribes, orders, dispenses, administers, supplies or otherwise distributes any Schedule II amphetamine or Schedule II amphetamine like anorectic drug or Schedule II sympathomimetic amine drug or compound thereof, or any salt, compound, isomer, derivative or preparation of the foregoing which are chemically equivalent thereto, or other nonnarcotic Schedule II stimulant drug, which drugs or compounds are classified under ~~schedule~~ Schedule II of the Alabama Uniform Controlled Substances Act, ~~Section Ala. Code § 20-2-24~~, to any person except for the therapeutic treatment of:

- (i) Narcolepsy.
- (ii) Hyperkinesis.

(iii) Brain dysfunction of sufficiently specific diagnosis or etiology which clearly indicates the need for these substances in treatment or control.

(iv) Epilepsy.

(v) Differential psychiatric evaluation of clinically significant depression; provided, however, that such treatment shall not extend beyond a period of 30 days unless the patient is referred to a licensed practitioner specializing in the treatment of depression.

(vi) Clinically significant depression shown to be refractory to other therapeutic modalities; provided, however, that such treatment shall not extend beyond a period of 30 days unless the patient is referred to a licensed practitioner specializing in the treatment of depression; or for the clinical investigation of the effects of such drugs or compounds, in which case an investigative protocol must be submitted to and reviewed and approved by the State Board of Medical Examiners before the investigation has begun.

(v) A physician prescribing, ordering or otherwise distributing the controlled substances listed above in the manner permitted by subsection (u) above shall maintain a complete record which must include documentation of the diagnosis and reason for prescribing, the name, dose, strength, and quantity of the drug, and the date prescribed or distributed. The records required under this subsection shall be made available for inspection by the certifying board or its representative upon request. Those Schedule II stimulant drugs enumerated above shall not be dispensed or prescribed for the treatment or control of exogenous obesity.

(w) Failure to maintain for a patient a medical record which meets the minimum standards stated in the rules and regulations promulgated by the Commission.

(x) The violation of Ala. Code § 34-24-57, ~~Code of Ala. 1975~~, in that the licensee, who, during the preceding three (3) year period has had two or more final judgments or settlements, or has had a total of three or more final judgments or settlements, or both, resulting from a claim or action for damages for personal injuries caused by an error, omission or negligence in the performance of medical professional services, or in the performance of medical professional services without consent.

(y) Practicing medicine in violation of the provisions of the Infected Health Care Worker Management Act, Act 93-846.

(z) Failure to comply with any rule of the Board of Medical Examiners or Medical Licensure Commission.

Author: ~~Alabama Board of Medical Examiners, Wallace D. Mills~~ Medical Licensure Commission of Alabama.

Statutory Authority: Code of Ala. 1975, §§\_34-24-57, 34-24-360, 34-24-381, 34-24-382.

History: Filed May 6, 1983. Repealed and new rule adopted in lieu thereof: Filed May 1, 1984. Amended: Filed September 25, 1986. Amended: Filed January 26, 1994; effective March 3, 1994. Amended: Filed March 4, 2003; effective April 8, 2003. Amended: Filed April 29, 2005; effective June 3, 2005. Amended: Filed April 28, 2006; effective June 2, 2006. Amended: Filed November 30, 2007; effective January 4, 2008. Amended: Filed May 5, 2010; effective June 9, 2010. Amended: Filed April 5, 2011; effective May 10, 2011. Amended: Filed November 26, 2014; effective December 31, 2014. Amended: Filed December 10, 2018; effective January 24, 2019. Amended: Published October 29, 2021; effective December 13, 2021.



EXHIBIT

F

STATE of ALABAMA  
MEDICAL LICENSURE COMMISSION

MEMORANDUM

**To:** Medical Licensure Commission

**From:** Rebecca Robbins

**Date:** February 2, 2026

**Subject:** FSMB Call for Comments: Reports and Recommendations of the FSMB Workgroup on Oversight of Clinical-Decision Making

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In 2024, the FSMB convened the Workgroup on Oversight of Clinical Decision Making in response to the consolidation, corporatization, and increasingly complex ownership and management structures in the practice of medicine that has occurred over recent decades. The Workgroup was charged with assessing systemic factors impacting physicians' clinical decision-making, analyzing the influence of payors and third parties on standards of care, evaluating associated administrative burdens on the physician workforce, including physician well-being and patient safety, and examining the effect these factors have on medical and osteopathic boards' ability to effectively carry out their statutory missions.

The draft report includes the following principles and recommendations for medical/osteopathic boards:

- **Primacy of Patient Safety in All Practice Settings** – physicians' professional and ethical obligations to patients apply broadly and regardless of practice setting, employment structure, or contractual arrangements
- **Strengthen Corporate Practice of Medicine Oversight** – where permitted by law, boards should work with relevant state agencies, legislatures, attorneys general, and governors to review their state's enforcement approach to the corporate practice of medicine
- **Establish Standard for Clinical Independence** – articulate clear expectations regarding clinical independence and improper interference by non-physicians in clinical decision making
- **Require Meaningful Physician Ownership and Involvement** – should be defined as requiring more than holding title to shares in the practice, such as physician owners should be duly licensed in the state where the practice operates, be physically present and engaged in delivering medical care or be substantially involved in practice management, and have ultimate authority over key practice decisions

- **Address Licensure of Out of State Physician Practice Owners** – should physicians who own or govern medical practices be required to hold licensure in the state the practice operates
- **Clarify Physicians’ Duty to Advocate and Report** – professional and ethical duty to advocate for patients and to report circumstances that interfere with clinical decision making
- **Promote Transparency in Ownership and Practice** – encourage practice ownership transparency to support patients’ right to know
- **Educate Licensees about Practice Structures and Professional Obligations** – develop educational materials for understanding the professional and legal implications of practice structures and employment arrangements
- **Collaborate with Other Regulators and Interested Parties** – collaborate with state attorneys general, state insurance departments, federal agencies, and other stakeholders to address systemic issues affecting clinical decision-making
- **Address Utilization Management and Prior Authorization Concerns** – clarify physicians’ obligations in the context of utilization management and advocate for reforms to ensure utilization review does not improperly interfere with clinical decision-making and medically necessary patient care
- **Integrate with Physician Well-being and Burnout Initiatives** – recognize that systemic interference with clinical decision-making may contribute to physician burnout and integrate these concerns into wellbeing initiatives

For licensees, the report recommends understanding professional obligations, carefully evaluating practice arrangements and employment contracts, maintaining clinical independence, fulfilling advocating and reporting duties, ensuring transparency with patients, and seeking support when facing moral distress or ethical conflicts.

Comments are due by March 13, 2026. If the Commission does not wish to submit any comments, this item should be received as information.

1 **Report and Recommendations of the FSMB Workgroup on Oversight of**  
2 **Clinical Decision-Making**

3 **Draft, January 2026**

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4  
5 **Executive Summary**

6 The landscape of medical practice in the United States has undergone dramatic  
7 transformation in recent decades. Consolidation, corporatization, and increasingly  
8 complex ownership and management structures have fundamentally altered the context in  
9 which many physicians practice medicine and patients receive care.

10 The FSMB's Workgroup on Oversight of Clinical Decision-Making was established by  
11 FSMB Immediate Past Chair Katie L. Templeton, JD, in 2024 to better understand these  
12 systemic factors as they impact a physician's clinical decisions, review the potential  
13 influence of various entities on standards of care, and evaluate the associated  
14 administrative burdens on the physician workforce, including physician well-being and  
15 patient safety. This report summarizes the Workgroup's findings and recommendations to  
16 assist state medical boards, physicians, and other parties as they navigate an increasingly  
17 complex environment while maintaining fidelity to core professional obligations.

18  
19 The recommendations contained in this report are grounded in a fundamental principle:  
20 the primacy of patient safety. This principle holds that the fundamental role of all  
21 physicians is to safeguard the best interests of their patients above all other  
22 considerations, including personal, financial, or third-party interests. This principle  
23 derives from the social contract between the medical profession and society, which grants  
24 physicians the privilege of self-regulation in exchange for their commitment to place  
25 patient welfare foremost.

26 This report recommends that state medical boards support strengthening of protections for  
27 physicians' clinical independence to reaffirm that patient safety and welfare are the  
28 primary drivers of clinical decisions. It calls for a better understanding by all parties of the  
29 guardrails needed when physicians partner or contract with non-physician entities, and  
30 how to ensure accountability when physician independence is compromised. The report  
31 further urges boards to integrate concerns about institutional and financial pressures into  
32 broader physician well-being and burnout initiatives, recognizing that these are core  
33 patient-safety issues. Taken together, these recommendations operationalize the  
34 profession's social contract by translating physicians' fiduciary duties into clear  
35 expectations for licensees and actionable oversight strategies for boards. In doing so, the  
36 recommendations seek to preserve public trust in medical regulation in an era of rapid  
37 corporatization.

38 For state medical boards, these recommendations offer practical tools to address corporate  
39 influence in clinical care within existing statutory authority. For physicians, they clarify  
40 professional obligations and provide regulatory support when they advocate for patients in  
41 challenging practice settings. For patients and the public, they reinforce the expectation

42 that clinical decisions will be guided by patients' medical needs, not corporate or financial  
43 pressures.

44

DRAFT

45 **Section One: Introduction and Workgroup Charge**

46 *The Social Contract Between Medicine and Society*

47 The practice of medicine rests upon a social contract, first described by sociologist Paul  
48 Starr in the 1980s,<sup>1</sup> between the medical profession and society. Under this implied  
49 contract, society grants physicians significant autonomy, self-regulation, and professional  
50 privileges. In return, the medical profession accepts obligations to maintain competence,  
51 demonstrate integrity, place patient interests above self-interest, and enforce these  
52 standards at the level of clinical practice.<sup>2</sup>

53 Central to this social contract is the physician's fiduciary duty to patients: an obligation of  
54 undivided loyalty that requires physicians to act in patients' best interests even when  
55 doing so conflicts with their own interests or the interests of third parties.<sup>3,4,5</sup> This  
56 fiduciary relationship is foundational to patient trust, which is itself essential to effective  
57 medical care and patient safety.

58 The social contract and the fiduciary duties that it encompasses entail several core  
59 responsibilities for physicians:

- 60 • Place patient welfare above personal or institutional financial interests
- 61 • Maintain clinical independence and professional judgment
- 62 • Ensure transparency with patients regarding factors that may influence care
- 63 • Advocate for patients' access to appropriate, medically necessary care
- 64 • Report circumstances that compromise the ability to provide appropriate care

65 *Workgroup Charge*

66 The Workgroup on Oversight of Clinical Decision-Making was established by FSMB's  
67 Immediate Past Chair, Katie L. Templeton, JD, in 2024 and charged with assessing  
68 systemic factors impacting physicians' clinical decisions, analyzing the influence of  
69 payors and third parties on standards of care, and evaluating associated administrative  
70 burdens on the physician workforce, physician well-being, and patient safety. The  
71 Workgroup was further charged with examining the effect that these factors have on state  
72 medical boards' ability to effectively carry out their statutory missions and to provide  
73 guidance supporting ethical practice and the fulfillment of fiduciary duties to patients.

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<sup>1</sup> Starr, P. (1982). *The social transformation of American medicine*. Basic Books.

<sup>2</sup> Cruess, S. R., Cruess, R. L., & Steinert, Y. (2010). Linking the teaching of professionalism to the social contract: A call for cultural humility. *Medical Teacher*, 32(5), 357-359.

<sup>3</sup> Ludewigs, S., Narchi, J., Kiefer, L., & Winkler, E. C. (2025). Ethics of the fiduciary relationship between patient and physician: The case of informed consent. *Journal of Medical Ethics*, 51(1), 59–66.

<sup>4</sup> Rodwin, M. A. (1995). Strains in the fiduciary metaphor: Divided physician loyalties and obligations in a changing health care system. *American Journal of Law & Medicine*, 21(2-3), 241-257.

<sup>5</sup> Chervenak FA, McCullough LB. (2003) Physicians and hospital managers as cofiduciaries of patients: rhetoric or reality? *J Healthcare Manag*. 48(3), 172–9.

74 The Workgroup engaged in extensive deliberation over nearly two years, reviewing legal  
75 and policy literature, examining enforcement actions, consulting with experts, and  
76 considering the perspectives of multiple interested parties. The Workgroup identified  
77 several recurring themes: the potential for tension between institutional interests and a  
78 physician’s professional obligations; the importance of clinical independence; the value of  
79 transparency; and the fundamental principle that patient safety must take primacy over all  
80 other considerations.

81

### 82 **Section Three: Evolution of Practice Structures and Emerging Challenges**

83 Historically, most physicians in the United States practiced independently or in small  
84 physician-owned groups. In recent years, however, the health care delivery landscape has  
85 undergone a fundamental transformation. Rather than own their practices, physicians  
86 increasingly practice as employees of hospitals, health systems, or in practices closely  
87 aligned with a private investor or non-physician entity. According to an Avalere report  
88 from early-2024, about 77.6% of all practicing physicians in the United States were  
89 employees of hospitals, health systems, and other entities.<sup>6</sup>

90 These changes have occurred in response to multiple factors: increasing practice overhead  
91 and administrative complexity, student loan burdens, a desire for work-life balance, and  
92 perceived advantages to physicians of organizational affiliations.<sup>7</sup> While these models  
93 may offer legitimate benefits—including access to capital, technology, administrative  
94 support, and reduced individual liability—they also introduce potential conflicts between  
95 physicians’ professional obligations and the financial or operational interests of the  
96 affiliated non-physician or investor entities.

97 Several specific structural developments and external influences can present tradeoffs and  
98 tensions between physicians’ clinical decision-making and the priorities of non-physician  
99 actors or entities, including ownership, financing, and employment arrangements that  
100 shape how physicians practice:

- 101 **1. Integrated Professional Corporation-Management Services Organization**  
102 **(PC-MSO) Structures:** Hospitals, virtual care entities, managed care, and  
103 practices aligned with private investment often rely on a model wherein the  
104 professional corporation (PC) owned by licensed physicians has a management  
105 services agreement with a lay-owned management services organization (MSO).  
106 The management service agreement should recognize the PC’s control over all  
107 clinical decisions and the medical practice itself, while delegating administrative

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<sup>6</sup> Physicians Advocacy Institute, & Avalere Health. (2024, April). *PAI-Avalere study on physician employment–practice ownership trends 2019–2023*.  
<https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Study-on-Physician-Employment-Practice-Ownership-Trends-2019-2023>

<sup>7</sup> Darves, B. (2014, July 23). *Understanding the physician employment “movement”*. NEJM CareerCenter. <https://resources.nejmcareercenter.org/article/understanding-the-physician-employment-movement/>

108 and operational services to the MSO. While designed to comply with corporate  
109 practice of medicine prohibitions, these structures may sometimes result in  
110 effective control over clinical operations by non-physician entities.

111 2. **Increased Need for Private Investment:** Whether developing an innovative new  
112 care model or wanting capital for new equipment or facing revenue shortfalls,  
113 many physician practices have increasingly turned to outside investment sources,  
114 including private equity or venture capital financing. In some instances, aligning  
115 with outside investment can enable practice growth, improve operational  
116 efficiencies, modernize the practice's technology, and help struggling practices  
117 stay open rather closing or consolidating with a larger health system. However,  
118 third-party investors have no ethical or legal duties to patients. In private equity,  
119 for example, investments typically involve aggressive debt financing and  
120 expectations for rapid return on investment, potentially creating pressure to  
121 prioritize profitability over patient care.<sup>8</sup>

122 3. **Employment by Health Systems, Hospitals, and Payors:** Physicians  
123 increasingly practice as employees of health systems, hospitals, or payors rather  
124 than as independent practitioners. Employment arrangements can align physicians'  
125 incentives with institutional financial and operational priorities, potentially  
126 influencing clinical decision-making. Examples include:

- 127 • Hospital and health system employment structures that tie clinical authority  
128 and resource allocation to centralized administrative leadership, which may  
129 prioritize service line growth, throughput, or cost savings.
- 130 • Employment by payors or payor-affiliated entities, in which physicians' roles  
131 and performance expectations may be closely linked to utilization reduction,  
132 cost-containment goals, or adherence to payor-designed care pathways.
- 133 • Productivity-based compensation models, such as those relying heavily on  
134 relative value units or visit volume targets, which can pressure physicians to  
135 increase encounters, favor higher-reimbursed services, or limit time per  
136 patient, creating tension with individualized, patient-centered care.

137 4. **Employment Agreements Can Include Restrictive Covenants:** Physicians sign  
138 employment agreements containing restrictive covenants, non-disclosure  
139 agreements, and non-disparagement clauses. While practices might have  
140 legitimate interests in protecting their investments in workforce and promoting  
141 stability, these contractual provisions may inhibit their ability to advocate for  
142 patients, report safety concerns, or exercise independent professional judgment.<sup>9</sup>

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<sup>8</sup> Borsa, A., Bejarano, G., Ellen, M., & Bruch, J. D. (2023). Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: Systematic review. *BMJ*, 382, e075244. <https://doi.org/10.1136/bmj-2023-075244>

<sup>9</sup> American Medical Association. (2025). *Legislative approaches to curb corporate influence in health care: State-level policy options to protect the integrity of medical practice amidst increased investment in health care by private equity firms and other corporate entities*. American Medical Association. <https://www.ama-assn.org/system/files/state-leg-approaches-to-curb-corporate-influence-in-health-care.pdf>

143 **5. External Payor Controls on Treatment Through Utilization Management:**  
144 Though different from ownership or employment structures, third-party payors  
145 exert influence over clinical decisions through prior authorization requirements,  
146 utilization review, and other cost-containment mechanisms. While some oversight  
147 of medical necessity may be appropriate, aggressive utilization management can  
148 interfere with physician judgment and delay or deny medically appropriate  
149 care.<sup>10,11</sup>

150 These systemic changes and structural developments in the practice of medicine pose a  
151 series of oversight issues for medical boards to address:

152 *Overall Challenges*

- 153 1. Insufficient transparency regarding ownership and control structures of clinical  
154 practices
- 155 2. Difficulty determining accountability when clinical decisions involve multiple  
156 parties
- 157 3. Lack of updated guidance reflecting contemporary practice realities and ensuring  
158 licensees understand their legal and ethical duties when facing institutional or  
159 financial pressure
- 160 4. Limited jurisdiction over non physician entities influencing clinical care.

162 *PC-MSO Model Considerations*

- 163 1. Determining whether arrangements comply with state CPOM laws
- 164 2. Identifying the party truly controlling clinical decisions when harm occurs
- 165 3. Addressing situations where the controlling entity is outside state medical board  
166 jurisdiction
- 167 4. Enforcing ethical obligations when contractual arrangements constrain physician  
168 autonomy

169 *Payor Coverage Considerations*

- 170 1. Determining whether physicians who fail to advocate for patients when care is  
171 inappropriately denied have violated their professional duties
- 172 2. Deciding whether utilization review physicians practicing in other states should be  
173 subject to licensure requirements
- 174 3. Appropriately addressing situations where payor denials lead to patient harm
- 175 4. Clarifying physicians' ethical obligations when they disagree with coverage  
176 determinations

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<sup>10</sup> Pickern, J. S. (2025). Prior authorizations and the adverse impact on continuity of care. *The American Journal of Managed Care*, 31(4), 163–165. <https://doi.org/10.37765/ajmc.2025.89721>

<sup>11</sup> American Medical Association. (2025). *2024 AMA prior authorization physician survey*. American Medical Association. <https://www.ama-assn.org/system/files/prior-authorization-survey.pdf>

177 *Employment Contract Considerations*

- 178 1. Offering guidance about whether specific contractual provisions that prevent  
179 physicians from reporting concerns or advocating for patients violate professional  
180 obligations
- 181 2. Protecting physicians from retaliation who report concerns in good faith
- 182 3. Deciding whether boards should prohibit certain contractual provisions as  
183 inconsistent with professional obligations

184 *Physician Education and Resources for Well-Being*

- 185 1. Understanding systemic factors that contribute to physician burnout, impairment  
186 and suboptimal performance
- 187 2. Ensuring board policies do not exacerbate burnout but promote well-being
- 188 3. Recognizing that physicians struggling under unsustainable conditions often need  
189 support, rather than discipline

190

191 **Section Four: Principles**

192 The primary recommendations in this report rest upon the following core principles,  
193 which should guide state medical boards, licensees, and other entities in addressing the  
194 challenges posed by contemporary practice structures.

195 **Principle 1: Primacy of Patient Safety and Best Interests**

196 **The fundamental obligation of every physician is to safeguard the best interests of**  
197 **patients above all other considerations, including personal, financial, or corporate**  
198 **interests.**

199 This principle is the bedrock of medical professionalism. It means that when conflicts  
200 arise between patient welfare and other interests—whether the physician's financial gain,  
201 an employer's profitability, or cost containment efforts—the patient's interest must  
202 prevail. The primacy of patient safety is not merely aspirational; it is a binding  
203 professional duty that is enforceable by state medical boards.

204 **Principle 2: Clinical Independence and Professional Judgment**

205 **Physicians, in conjunction with patients in a shared decision-making process, must**  
206 **retain ultimate authority over clinical decisions and must not allow non-physicians**  
207 **or corporate entities to interfere with, control, or unduly influence their professional**  
208 **medical judgment.**

209 Clinical independence means that decisions regarding diagnosis, treatment, referrals, and  
210 other medical matters must be made by licensed physicians based on their professional  
211 judgment, prevailing evidence and standards, and the individual patient's circumstances.  
212 While physicians may appropriately consider input from colleagues, institutional

213 protocols based on evidence and resource constraints, the ultimate clinical decision must  
214 largely remain with the physician, free from improper interference.

### 215 **Principle 3: Fiduciary Duty and Undivided Loyalty**

216 **Physicians owe fiduciary duties to their patients, requiring them to act with**  
217 **undivided loyalty to patient interests and to avoid (or appropriately manage)**  
218 **conflicts of interest that may arise through their employment arrangement.**

219 The physician-patient relationship is fiduciary in nature. Physicians must disclose  
220 conflicts of interest to patients, avoid arrangements that compromise their loyalty to  
221 patients, and structure their practices to minimize the influence of financial incentives that  
222 diverge from patient welfare. When conflicts are unavoidable, they must be transparently  
223 disclosed and carefully managed.

### 224 **Principle 4: Transparency and Informed Consent**

225 **Patients have the right to know who is making decisions about their care, what**  
226 **factors may influence those decisions, and what organizational or financial**  
227 **relationships may affect the care they receive.**

228 Transparency is essential to informed consent and to maintaining patient trust. Patients  
229 have a right to know about limitations on treatment options imposed by institutional,  
230 payor, or other policies. This transparency enables patients to make informed choices  
231 about their care.

### 232 **Principle 5: Physician Duty to Advocate and Report**

233 **Physicians have a professional obligation to advocate for their patients' access to**  
234 **medically appropriate care and to report circumstances that improperly interfere**  
235 **with clinical decision-making or compromise patient safety.**

236 Physicians must not be passive participants when corporate policies, payor restrictions, or  
237 other systemic factors improperly interfere with patient care. Physicians have a duty to  
238 advocate for their patients and, when necessary, to report improper interference to their  
239 state medical board or other appropriate authorities. State medical boards should protect  
240 physicians who report in good faith from retaliation.

### 241 **Principle 6: Accountability at All Levels**

242 **All parties involved in health care delivery—physicians, health care organizations,**  
243 **payors, and others—share responsibility for ensuring that patient safety is protected**  
244 **and that physicians can fulfill their professional obligations.**

245 While physicians bear primary responsibility for their clinical decisions, accountability  
246 must extend to organizations and entities that structure practice arrangements, impose  
247 productivity expectations, implement utilization management programs, or otherwise  
248 influence clinical care. State medical boards should work to ensure that these entities do  
249 not undermine physicians' ability to meet professional obligations.

250 **Principle 7: State Medical Board Authority and Responsibility**

251 **State medical boards have the authority and responsibility to regulate physicians in**  
252 **a manner that protects patient safety, maintains professional standards, and holds**  
253 **licensees accountable for fulfilling their fiduciary duties to patients, regardless of**  
254 **practice setting or employment structure.**

255 State medical boards' fundamental mission—protecting the public—does not change  
256 when physicians enter employment relationships or when corporate entities become  
257 involved in health care delivery. Boards should adapt their oversight approaches to  
258 address contemporary practice structures while maintaining clear expectations for licensee  
259 conduct.

260

261 **Section Six: Recommendations**

262 The following recommendations are offered primarily to state medical boards in support  
263 of their efforts to regulate the practice of medicine in the interest of protecting patients.  
264 Additional recommendations are offered to licensees. All recommendations below are  
265 offered with the aim to preserve physician clinical independence, ensure accountability,  
266 promote transparency, and ultimately protect patient safety.

267 **Recommendation 1: Affirm the Primacy of Patient Safety in All Practice Settings**

268 **State medical boards should clearly articulate that physicians' professional and**  
269 **ethical obligations to patients apply broadly and regardless of practice setting,**  
270 **employment structure, or contractual arrangements.**

271 All licensees must understand that entering an employment relationship or contracting  
272 with non-physician entities does not diminish their fiduciary duties to patients. State  
273 medical boards should:

- 274 • Issue clear policy statements or guidance documents affirming that professional  
275 obligations persist across all practice structures
- 276 • Communicate regularly with licensees about these expectations
- 277 • Include discussion of professional obligations in varied practice settings in board  
278 publications, licensee communications, and continuing education programs
- 279 • Hold licensees accountable when they fail to uphold professional standards, while  
280 simultaneously considering mitigating systemic factors

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286 **Recommendation 2: Strengthen Corporate Practice of Medicine Oversight**

287 **State medical boards in jurisdictions with corporate practice of medicine statutes**  
288 **should work with relevant state agencies, state legislatures, state attorneys general**  
289 **and Governors, where permitted by law, to review their state’s enforcement**  
290 **approach. Collaboration is strongly recommended to strengthen guidance to**  
291 **licensees and enforcement actions against improper arrangements. In simple terms,**  
292 **corporate practice of medicine laws are intended to prevent nonphysicians from**  
293 **controlling clinical decision-making, even when they own or manage a practice.**

294 Specific actions could include:

- 295 • Evaluating whether current statutes, regulations, and enforcement practices  
296 adequately protect against improper corporate influence over clinical decisions  
297 and whether additional guardrails are needed
- 298 • Providing clearer guidance to licensees regarding what constitutes “control” over  
299 clinical operations and appropriate physician involvement in practice governance
- 300 • Developing educational materials explaining CPOM requirements and potential  
301 pitfalls of various practice structures
- 302 • Collaborating with state attorneys general and other enforcement agencies on  
303 CPOM violations
- 304 • Considering registration requirements for management services organizations that  
305 contract with physician practices

306 **Recommendation 3: Establish Standards for Clinical Independence**

307 **State medical boards should articulate clear expectations regarding physician**  
308 **clinical independence and improper interference by non-physicians in clinical**  
309 **decision-making. By clearly articulating these boundaries, boards reinforce that the**  
310 **profession’s autonomy is justified only when it is exercised in service of patient**  
311 **welfare.**

312 Such guidance may specify that in all practice settings:

- 313 • Physicians should retain ultimate authority over clinical decisions, including  
314 diagnosis, treatment, referrals, prescribing, and care coordination
- 315 • Non-physicians and corporate entities should not interfere with, control, or unduly  
316 direct physicians' professional medical judgment, including in mandating specific  
317 treatment decisions and establishing patient volume or time limits
- 318 • Physicians should not allow productivity metrics, financial incentives, or  
319 institutional policies to compromise their clinical judgment or patient safety
- 320 • Employers and non-physician entities should not discipline, terminate, or retaliate  
321 against physicians for making clinical decisions in patients' best interests

- 322 • Contractual provisions that prevent physicians from exercising independent  
323 professional judgment may be contrary to public policy and professional  
324 obligations

325 Examples of impermissible interference may include:

- 326 • Mandating specific treatment decisions, such as requiring discharge before it is  
327 medically appropriate or prohibiting certain referrals
- 328 • Establishing patient volume or time limits that prevent physicians from providing  
329 adequate care
- 330 • Retaliating against physicians who advocate for patients or raise safety concerns
- 331 • Implementing policies that prioritize financial considerations over medical  
332 appropriateness

#### 333 **Recommendation 4: Require Meaningful Physician Ownership and Involvement**

334 **In jurisdictions with corporate practice of medicine laws, state medical boards**  
335 **should require that physician owners demonstrate meaningful ownership through**  
336 **substantial engagement in delivering care or managing the practice.**

337 Meaningful ownership should be defined as requiring more than holding title to shares in  
338 the practice. It may include requirements that physician-owners:

- 339 • Be duly licensed in the state where the practice operates
- 340 • Be physically present and actively engaged in delivering medical care or  
341 substantively involved in practice management
- 342 • Retain ultimate authority over key practice decisions, including clinical policies,  
343 hiring/firing of clinical staff, contracting with payors, and financial distributions

#### 344 **Recommendation 5: Address Licensure of Out-of-State Physician Practice Owners**

345 **It is strongly recommended that state medical boards consider whether physicians**  
346 **who own or govern medical practices providing care in their state should be**  
347 **required to hold licensure in that state, thereby subjecting them to the board's**  
348 **jurisdiction and ethical standards.**

349 Currently, several states with CPOM statutes do not require practice owners to be licensed  
350 in the state where the practice operates, so long as the owner holds an active medical  
351 license elsewhere. This creates accountability gaps when out-of-state owners exert control  
352 over practices but are not subject to the state medical board's authority. Requiring owners  
353 who control clinical policies to be subject to the board's jurisdiction closes critical  
354 accountability gaps and aligns legal authority with real-world influence.

355 State medical boards should:

- 356 • Evaluate whether requiring in-state licensure for practice owners and directors  
357 would improve oversight

- 358 • Consider alternatives such as registration requirements or written attestations of  
359 compliance with state laws and professional standards
- 360 • Collaborate with other state medical boards and the FSMB to address multistate  
361 practice ownership issues

362 **Recommendation 6: Clarify Physicians' Duty to Advocate and Report**

363 **State medical boards should remind physicians that they have a professional and**  
364 **ethical duty to advocate for patients when care is inappropriately restricted and to**  
365 **report circumstances to relevant bodies that improperly interfere with clinical**  
366 **decision-making.**

367 Guidance should specify that:

- 368 • When payors deny or delay medically necessary care and place patients at high  
369 risk of harm, physicians should advocate for their patients, including through  
370 appeal processes
- 371 • When employers, practice owners, or non-physician entities create unsafe  
372 conditions, physicians should raise concerns through appropriate channels
- 373 • Physicians have a duty to report to the state medical board situations where non-  
374 physicians improperly and unduly control clinical decisions or where a practice's  
375 policies systematically compromise patient safety
- 376 • Physicians who report in good faith are exercising their professional obligations  
377 and should be protected from retaliation
- 378 • Non-disclosure and non-disparagement agreements that prevent physicians from  
379 reporting patient safety concerns, quality problems, or regulatory violations may  
380 be contrary to professional obligations and public policy
- 381 • Refusal to sign impermissible contractual provisions is consistent with licensees'  
382 professional and ethical obligations

383 Boards should establish clear reporting mechanisms and should investigate reports of  
384 improper interference with clinical decision-making.

385 **Recommendation 8: Promote Transparency in Ownership and Practice**  
386 **Arrangements**

387 **State medical boards should encourage transparency regarding practice ownership**  
388 **structures in order to support patients' right to know about factors that may**  
389 **influence clinical decisions.**

390 Enhanced transparency empowers patients to make informed choices about their care and  
391 enables boards to identify potentially problematic arrangements.

392

393

394 **Recommendation 9: Educate Licensees About Practice Structures and Professional**  
395 **Obligations**

396 **State medical boards should develop educational materials to help physicians**  
397 **understand the professional and legal implications of various practice structures and**  
398 **employment arrangements. Educational materials on patient advocacy with non-**  
399 **physician partners should also be developed.**

400 Educational initiatives should:

- 401 • Explain CPOM requirements and the rationale for these protections
- 402 • Provide guidance on evaluating employment contracts and identifying problematic  
403 provisions
- 404 • Clarify professional obligations regarding clinical independence and patient  
405 advocacy
- 406 • Offer case examples illustrating appropriate and inappropriate practice  
407 arrangements
- 408 • Provide resources for physicians who encounter improper interference with  
409 clinical decisions
- 410 • Provide resources to underscore the responsibilities and obligations of physician  
411 owners

412 Education is particularly important for residents, early-career physicians, and those  
413 transitioning from training to practice, who may be most vulnerable to entering  
414 problematic arrangements.

415 **Recommendation 10: Collaborate with Other Regulators and Interested Parties**

416 **State medical boards should work collaboratively with state attorneys general, state**  
417 **insurance departments, federal agencies, and others to address systemic issues**  
418 **affecting clinical decision-making.**

419 Collaboration could include, where permitted by law:

- 420 • Joint enforcement actions against entities that violate CPOM laws or engage in  
421 improper interference with clinical decisions
- 422 • Coordinated policy development to address emerging challenges
- 423 • Engagement with professional associations, specialty societies, and physician  
424 advocacy organizations
- 425 • Participation in federal and state legislative efforts to protect physician clinical  
426 independence and patient safety

427 Many of the challenges identified in this report exceed the jurisdiction of any single  
428 regulatory body and require coordinated responses.

429 **Recommendation 11: Address Utilization Management and Prior Authorization**  
430 **Concerns**

431 **State medical boards should clarify physicians' professional obligations in the**  
432 **context of utilization management and advocate, where permissible by law, for**  
433 **reforms to ensure that utilization review does not improperly interfere with clinical**  
434 **decision-making and medically necessary patient care.**

435 State medical boards should:

- 436 • Clarify that physicians retain responsibility for ensuring patients receive medically  
437 necessary care, even when payors initially deny coverage and/or payment
- 438 • Support physicians in advocating for patients through appeal processes when care  
439 is inappropriately denied and patients are put at risk of harm
- 440 • Consider whether out-of-state physicians performing utilization review for  
441 patients in the board's jurisdiction should be required to hold licensure in that  
442 state, in accordance with state insurance regulations.
- 443 • Advocate for state legislation requiring that medical necessity determinations be  
444 made by physicians licensed in that state and practicing in the same or a similar  
445 specialty
- 446 • Support efforts to streamline prior authorization processes and reduce unnecessary  
447 administrative burdens on physicians and patients
- 448 • Work with state insurance departments to address situations where utilization  
449 management systematically compromises patient care

450 Boards should recognize that while utilization review serves legitimate purposes, it must  
451 not become a mechanism for improperly overriding physician clinical judgment or  
452 denying medically appropriate care.

453 **Recommendation 12: Integrate with Physician Well-being and Burnout Initiatives**

454 **State medical boards should recognize that systemic interference with clinical**  
455 **decision-making may contribute to physician burnout and should integrate these**  
456 **concerns into well-being initiatives.**

457 As articulated in FSMB's policy on Physician Wellness and Burnout, adopted by FSMB's  
458 House of Delegates in 2018, state medical boards have a role to play in supporting  
459 physician well-being that is directly related to their statutory mission to protect the public.  
460 With respect to clinical decision-making challenges, boards should:

- 461 • Acknowledge that systemic factors—productivity pressures, administrative  
462 burdens, financial pressure, moral distress from inability to provide appropriate  
463 care—contribute to burnout
- 464 • Consider systemic factors as mitigating circumstances when evaluating physician  
465 performance or conduct issues

- 466 • Support physicians who report unsafe working conditions or improper interference  
467 with clinical judgment
- 468 • Collaborate with physician health programs to address burnout related to practice  
469 structure challenges
- 470 • Advocate for systemic reforms to reduce administrative burdens and support  
471 sustainable practice conditions

472 Protecting physician well-being and protecting patient safety are complementary goals.

473

#### 474 ***Recommendations for Licensees***

475 While the primary recommendations listed above are directed to state medical boards,  
476 licensed physicians themselves also bear responsibility for upholding professional  
477 standards and fulfilling fiduciary duties to patients. The following guidance is offered to  
478 licensees:

#### 479 **Recommendation 13: Understand Your Professional Obligations**

480 Physicians must recognize that professional and ethical obligations persist regardless of  
481 employment status or practice structure. Fiduciary duties to patients are not negotiable,  
482 cannot be overridden by employer or payor demands, and cannot be waived by contract.

#### 483 **Recommendation 14: Carefully Evaluate Practice Arrangements and Employment 484 Contracts**

485 Before entering employment agreements or contracting with non-physician entities,  
486 physicians should:

- 487 • Thoroughly review all contractual provisions, preferably with an attorney familiar  
488 with that state's health care law and medical practice regulations
- 489 • Evaluate whether the arrangement preserves clinical independence and allows  
490 fulfillment of professional obligations
- 491 • Scrutinize restrictive covenants, particularly non-disclosure and non-  
492 disparagement provisions
- 493 • Ensure that compensation arrangements do not create problematic incentives to  
494 undertreat or overtreat
- 495 • Verify that the practice structure complies with state corporate practice of  
496 medicine laws

497 Physicians should be wary of arrangements that seem "too good to be true" or that offer  
498 nominal ownership without meaningful authority.

499

500

501 **Recommendation 15: Maintain Clinical Independence**

502 Physicians should retain ultimate authority over clinical decisions. When employers, non-  
503 physician entities, or payors attempt to interfere with clinical judgment in ways that  
504 compromise patient care, physicians should:

- 505 • Advocate firmly for their patients' best interests
- 506 • Raise concerns about directives that violate professional obligations or  
507 compromise patient safety
- 508 • Document attempts to interfere with clinical decision-making
- 509 • Report improper interference through appropriate channels, including to the state  
510 medical board, as may be necessary

511 **Recommendation 16: Fulfill the Duty to Advocate and Report**

512 Physicians have an affirmative obligation to advocate for patients and to report  
513 circumstances that improperly interfere with clinical care. This includes:

- 514 • Appealing prior authorization denials when care is medically necessary
- 515 • Raising concerns with employers when institutional policies compromise patient  
516 safety
- 517 • Reporting to the state medical board situations where non-physicians control  
518 clinical decisions or where corporate entities systematically prioritize profits over  
519 patient welfare

520 Physicians should not allow fear of retaliation to prevent them from fulfilling these duties.

521 **Recommendation 17: Ensure Transparency with Patients**

522 Upon patient request, physicians should make reasonable efforts to inform patients about  
523 factors that may affect care. Informed consent generally requires that patients be informed  
524 and understand who is making decisions about their care and what factors may influence  
525 those decisions.

526 **Recommendation 18: Seek Support When Facing Moral Distress or Ethical Conflicts**

527 When systemic factors create moral distress or ethical conflicts, physicians should seek  
528 support from colleagues, professional organizations, ethics consultants, or physician  
529 health programs. The state medical board may also be able to provide guidance on  
530 professional obligations.

531

532 **Scope and Limitations**

533 While the Workgroup's charge focused on regulatory implications for state medical  
534 boards, it recognizes that many underlying drivers of corporatization (e.g., reimbursement  
535 policy, antitrust enforcement, and federal regulation) lie beyond the direct authority of

536 boards. This report therefore concentrates on tools and strategies that are realistically  
537 within board jurisdiction, while identifying areas where collaboration with other state and  
538 federal actors is necessary.

539

## 540 **Conclusion**

541 The transformation of medical practice has created challenges for physicians seeking to  
542 fulfill their professional obligations, for patients navigating an increasingly complex  
543 health care system, and for state medical boards charged with regulating the medical  
544 profession. Corporate entities may exercise influence over clinical care, in ways that can  
545 create tension between the professional values held by licensed physicians and financial  
546 expectations.

547 State medical boards play a vital role in upholding the values of the profession in light of  
548 evolving practice structures, while maintaining fidelity to the social contract between  
549 medicine and society. By implementing the recommendations in this report, boards can  
550 provide clarity to licensees, hold all parties accountable, and ensure that the privilege of  
551 practicing medicine remains coupled with the responsibility to place patient welfare above  
552 all else.

553

554 **Appendix A: Glossary of Key Terms**

555 **Administrative burden:** Cumulative non-clinical tasks and requirements (such as prior  
556 authorization, extensive documentation, productivity tracking, and electronic health  
557 record workflows) that consume physician time and attention, contribute to burnout, and  
558 may detract from patient care.

559 **Clinical independence:** The ability and authority of a licensed physician to make  
560 diagnosis, treatment, referral, and care-coordination decisions based on professional  
561 judgment and the individual patient's needs, without improper interference, control, or  
562 direction by non-physician entities.

563 **Corporate practice of medicine (CPOM):** A legal doctrine, recognized in many states,  
564 that restricts or prohibits unlicensed individuals and lay corporations from owning  
565 medical practices or employing physicians, to prevent non-physician control of clinical  
566 decision-making and to safeguard patient welfare.

567 **Fiduciary duty:** The legal and ethical obligation of physicians to act with undivided  
568 loyalty in the best interests of their patients, placing patient welfare above personal,  
569 financial, or institutional interests and managing or avoiding conflicts of interest.

570 **Management services organization (MSO):** A non-clinical entity, typically owned by  
571 non-physicians or corporate investors, that contracts with physician practices or  
572 professional corporations to provide administrative, managerial, and business services.

573 **Meaningful ownership:** A form of physician ownership in which the physician not only  
574 holds an equity interest but also exercises real authority over key clinical and  
575 organizational decisions, participates in governance.

576 **Moral distress / moral injury:** The psychological and professional harm experienced by  
577 physicians when systemic or organizational constraints prevent them from providing care  
578 they believe is ethically or clinically appropriate, or when they are pressured to act  
579 contrary to their professional judgment.

580 **Non-compete covenant:** A contractual provision that limits where, when, or in what  
581 capacity a physician may practice medicine after leaving an employer or practice.

582 **Non-disclosure agreement (NDA):** A contractual clause or standalone agreement that  
583 restricts a physician from sharing specified information.

584 **Non-disparagement clause:** A contractual provision that prohibits a physician from  
585 making statements that could be perceived as critical of an employer or affiliated entity.

586 **Physician burnout:** A work-related syndrome characterized by emotional exhaustion,  
587 depersonalization or cynicism, and a reduced sense of professional effectiveness, often  
588 driven by administrative burdens, productivity pressures, and moral distress, and  
589 associated with increased risk of medical errors and workforce attrition.

590 **Prior authorization:** A utilization-management process by which a payor requires  
591 advance approval before agreeing to cover a prescribed medication, test, or service.

592 **Restrictive covenant:** A contractual term that limits a physician’s actions during or after  
593 employment—such as non-compete, non-disclosure, or non-disparagement provisions.

594 **Straw ownership:** An arrangement by which a physician is a nominal owner of a  
595 professional entity but lacks real authority over clinical or key business decisions, with  
596 effective control residing in a non-physician entity.

597 **Utilization Management / Utilization Review:** Processes used by payors and related  
598 entities to evaluate the medical necessity, appropriateness, efficiency, or cost of health  
599 care services, often including prior authorization, concurrent review, and retrospective  
600 review.

601





EXHIBIT

G

STATE of ALABAMA  
MEDICAL LICENSURE COMMISSION

MEMORANDUM

**To:** Medical Licensure Commission

**From:** Rebecca Robbins

**Date:** February 2, 2026

**Subject:** FSMB Call for Comments: Reports on Physician Collective Bargaining and Unionization

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Pursuant to the substantial increase in the number of employed physicians in the past decade which has created an increase in the number of physicians eligible for and participating in union membership, the FSMB's Ethics and Professionalism Committee was charged with studying emerging ethical challenges related to collective bargaining by physicians and its impact on state medical boards in fulfilling their responsibility to the public to support access to safe, quality medical care. The *Report on Physician Collective Bargaining and Unionization* seeks to raise awareness among state medical and osteopathic boards of the continuing shift in physician practice, particularly the corporate practice of medicine, and the potential for it to impact patient safety and access to care.

In summary, the report encourages medical and osteopathic boards to give consideration to:

- Reviewing its laws, rules, and regulations to clarify behavior that could potentially constitute unprofessional conduct in the context of a strike or collective action to distinguish lawful labor activities from conduct that might harm patients;
- Raising awareness among licensees regarding the Board's expectations of professional conduct in the context of labor activities;
- Providing educational resources to licensees on ethical participation in these activities;
- Developing protocols for responding to activities that may disrupt patient care; and
- Preparing a clear message in response to questions from licensees, the public, media, and other interested stakeholders in the event of strikes or collective actions.

In addition, the report charges physicians who join in collective bargaining with ensuring that the mission of the group they are joining is similarly aligned with the professional mission and goals of physicians in advancing agendas that prioritize and protect patients.

Comments are due by March 13, 2026. If the Commission does not wish to submit any comments, this item should be received as information.

1 **Report on Physician Collective Bargaining and Unionization**

2 **FSMB Ethics and Professionalism Committee**

3 **Executive Summary**

4 In April 2025, George M. Abraham, MD, MPH, Chair of the Federation of State Medical Boards  
5 (FSMB), charged FSMB's Ethics and Professionalism Committee with studying emerging ethical  
6 challenges related to collective bargaining by physicians and its impact on state medical boards  
7 in fulfilling their responsibility to the public to support access to safe, quality medical care.

8 Considering rapidly changing employment practices in medicine, it is pertinent to explore factors  
9 which may compel physicians, especially in recent times, to participate in collective bargaining  
10 and the effects it may have on medical regulation. Although this report focuses on physician  
11 participation in collective actions, it may similarly be applied to physician assistants/associates  
12 or other health care professionals regulated by the state medical or osteopathic board.

13 In the past decade, the number of employed physicians has increased substantially, thus  
14 increasing the number of physicians eligible for and participating in union membership. Resident  
15 unions have been prominent since the mid twentieth century and have helped drive advocacy  
16 for impactful positive changes, such as the 80-hour work week. However, an increase in strikes  
17 and other disruptive actions associated with collective bargaining, both domestically and  
18 internationally, merits ethical evaluation and understanding from the perspective of medical  
19 regulatory authorities.

20 The corporatization of medicine has also reshaped practice environments in ways that may  
21 conflict with professional obligations, particularly when financially driven policies compromise  
22 quality of, or access to, care. Evidence that private equity ownership may be associated with  
23 poorer patient outcomes, coupled with the widespread use of management services  
24 organizations and complex ownership structures, has heightened concern about non-physician  
25 influence over clinical practice and contributed to reports of moral injury and dignitary harm  
26 among physicians. It is understandable, therefore, that these developments may increasingly  
27 motivate physicians to seek a unified voice to advocate for policy and practice that will protect  
28 the safety and welfare of patients and physicians.

29 Neither union membership nor collective bargaining are inherently unethical as long as patient  
30 welfare is not threatened. Ethical concerns arise when disruptive collective actions such as work  
31 stoppages result in patient abandonment or undermine the primacy of patient welfare.

32 Secondly, such actions can also have an ultimate impact on patient care because of the  
33 general loss of patient trust and erosion of the public's perception of the motivation of the  
34 healthcare workforce. State medical boards have a statutory obligation to protect the public and  
35 promote access to safe medical care and should consider taking appropriate steps to fulfill this  
36 duty during any potentially disruptive actions. The Oregon Medical Board, as one example,  
37 recently demonstrated the importance of this principle when it responded to a strike action at a  
38 major medical system in the state. Though the Board played a limited role, as discussed further  
39 in this report, it prioritized patient interests and public safety within the confines of its statutory  
40 authority.

1 The committee found that changes in medical practice and collective bargaining in response to  
2 those changes may have important implications for medical regulation. State medical boards  
3 should be aware of evolving developments and conditions and prepare for potential disruptive  
4 actions that may affect patient access or safety, while refraining from taking a position in any  
5 bargaining dispute that falls outside their statutory and professional regulatory responsibilities.

6

## 1 **Definitions**

2 For the purposes of this report, the following definitions apply:

3 *Collective Bargaining* – Negotiation between an employer and a labor union or a professional  
4 group.<sup>1</sup>

5 *Corporate Practice of Medicine* – A legal doctrine, recognized in many U.S. states and  
6 territories, which restricts or prohibits unlicensed individuals and lay corporations from owning  
7 medical practices or employing physicians to prevent non-physician control of clinical  
8 decision-making and to safeguard patient welfare.

9 *Medical Society* – Ideally, a professional organization that primarily represents the interests and  
10 welfare of patients by advocating for improved health policy and the interests of physicians and  
11 other healthcare professionals.<sup>2</sup> Medical societies may advocate at the local, state, or federal  
12 level, but they generally do not negotiate directly with employers.

13 *National Labor Relations Act (NLRA)* – Federal legislation granting employees “the right to self-  
14 organization, to form, join, or assist labor organizations, to bargain collectively through  
15 representatives of their own choosing, and to engage in concerted activities for the purpose of  
16 collective bargaining or other mutual aid and protection.”<sup>3</sup>

17 *Union* - An organization of workers formed for the purpose of advancing its members' interests  
18 with respect to wages, benefits, and working conditions.<sup>4</sup>

## 19 **Introduction**

20 There has been a significant shift in the nature of physician practice in the United States over  
21 the past decade or so, with the percentage of corporately employed physicians increasing to  
22 74% as compared to just 29% in 2012.<sup>5</sup> In many instances, physicians report diminished  
23 autonomy in clinical decision making, poor working conditions, stress and burnout, changes to  
24 the physician-patient relationship, and related challenges. Given these changes to employment  
25 and ownership demographics in medicine, it becomes understandable that physicians may on  
26 occasion seek a collective voice to raise concerns and advocate for their ability to meaningfully  
27 provide safe and effective care to patients.

28 The primary goal of this report is to raise awareness among state medical and osteopathic  
29 boards of this continuing shift in medical practice and the potential for it to impact patient safety  
30 and access to care.

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<sup>1</sup> <https://www.merriam-webster.com/dictionary/collective%20bargaining>

<sup>2</sup> <https://jamesmckenna.org/glossary/medical-society/>

<sup>3</sup> <https://www.archives.gov/milestone-documents/national-labor-relations-act>

<sup>4</sup> <https://www.merriam-webster.com/dictionary/labor%20union>

<sup>5</sup> <https://www.researchgate.net/publication/362334941> *The Rise and Potential of Physician Unions, AMA CEJA 02 Supporting Efforts to Strengthen Medical Staffs Through Collective Action and/or Unionization (p. 116)*

1 The Ethics and Professionalism Committee is a standing committee of the FSMB established to  
2 address ethical and professional issues pertinent to medical regulation including licensure,  
3 discipline, and public protection. The committee examines emerging issues and ongoing ethical  
4 challenges, and its prior work has addressed issues such as expert witness review, use of social  
5 media, and ethical incorporation of artificial intelligence into clinical practice. In April 2025,  
6 FSMB Chair George M. Abraham, MD, MPH, charged the committee to study ethical and  
7 professional considerations related to unionization and collective bargaining by physicians and  
8 state medical boards due to the potential impact of such actions on patient access and safety. In  
9 its deliberations, the committee reviewed peer-reviewed and grey literature, including white  
10 papers of national bodies, and heard from several experts, including those representing the  
11 Allegheny County Medical Society, the Oregon Medical Board, and the American Medical  
12 Association's Council on Ethical and Judicial Affairs (CEJA). While the committee found the  
13 input of these organizations incredibly valuable, it also recognized and notes that there are a  
14 number of other national bodies considering the ethical implications of these issues that may  
15 have varying perspectives depending upon their organizations and professions.

16 The National Labor Relations Act (NLRA), signed into law in 1935 by President Franklin D.  
17 Roosevelt as part of New Deal labor reforms, permits employed physicians in non-supervisory  
18 positions to join labor unions. As of 2019, approximately 7.2% of physicians belonged to a  
19 union.<sup>6</sup> In terms of the inherent value of this option to address grievances and concerns, the  
20 American College of Physicians (ACP) has stated that collective bargaining can be used to  
21 "strengthen the patient-physician relationship, restore clinical autonomy, improve physician  
22 well-being, and promote professionalism."<sup>7</sup> From an ethics perspective, it is important to note  
23 that neither union membership nor collective bargaining are considered inherently unethical.  
24 However, issues of harm and unethical actions arise when physicians take actions that may  
25 subvert the primacy of patient welfare. Organized physician groups like ACP and the AMA CEJA  
26 discourage strikes due to the likelihood of patient harm but support collective bargaining in the  
27 interest of improved patient care, emphasizing non-disruptive tactics to achieve better systems  
28 of care, not simply better pay or working conditions.

29 A recent example of balancing these concerns occurred in Oregon, when the state's medical  
30 board (Oregon Medical Board) responded thoughtfully to a strike action at a major health care  
31 system in the state (see page 7.) Though the Board played a limited role, as summarized later  
32 in this report, it prioritized patient interests and public safety within the confines of its statutory  
33 abilities. When medical boards consider the issue of physician collective bargaining, it must be  
34 through a lens that emphasizes patient safety, access to care, and physicians' fiduciary duty to  
35 patient interests.

36

### 37 **Evolution of Physician Practice**

38 The corporate practice of medicine in the United States has dramatically reshaped clinical  
39 environments, while expecting physicians to maintain prevailing standards of care. Studies have

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<sup>6</sup> <https://www.ama-assn.org/system/files/advocacy-issue-brief-physician-unions.pdf>

<sup>7</sup> <https://www.acpjournals.org/doi/10.7326/ANNALS-24-03973>

1 shown that patient outcomes are sometimes poorer at hospitals acquired by private equity  
2 firms.<sup>8</sup> This could be due to increased emphasis placed on bottom-line incentives, which may be  
3 prioritized over patient safety and quality.<sup>9</sup> Tension between the financial interests of for-profit  
4 owners and the public's interest in high quality care can create "dignitary harm" (non-physical  
5 injury to a physician that results from being treated as less worthy, less equal, or not fully a  
6 person, such as through disrespect, humiliation, or stereotyping) and "moral injury"  
7 (psychological and spiritual distress that arises when a clinician's core moral values or  
8 professional ethics are violated, especially when system constraints prevent them from  
9 providing the care they believe is right for the patient) for physicians.

10 The practice of medicine has long been described as both an art and a science, reflecting  
11 physicians' professional judgement and independence in delivering individualized, patient-  
12 centered care. However, the corporatization of medicine has often required physicians to adhere  
13 to policies driven by financial and operational interests rather than clinical judgment. The  
14 erosion of much of the decision-making authority previously held by self-employed or contracted  
15 physicians may contribute to cognitive dissonance, stress, and burnout, which are already  
16 prevalent among health care professionals.

17 Many states have passed laws over the years that are aimed at limiting the corporate practice of  
18 medicine, but enforcement in these jurisdictions has been challenging and regulatory gaps  
19 persist. Common areas of ambiguity involve contracting with management-services  
20 organizations (MSOs), which provide practice and clinical support services that usually result in  
21 the MSO running the practice, even if physician owned. Another arrangement is the use of a  
22 "friendly physician" who owns the practice in title only while not clinically active at the practice  
23 location.<sup>10</sup>

24 Even operational decisions that appear benign, such as centralized scheduling, may remove  
25 flexibility from physicians regarding appointment availability and prioritization of urgent patient  
26 needs. Schedulers who work directly with a physician may have more knowledge of patient  
27 needs and this loss of flexibility can lead to frustration among physicians and patients alike.

28 The corporatization of medicine is also influencing how the notions of "access to care" and the  
29 "physician/patient relationship" are understood. Patients still seek the shared sense of trust,  
30 compassion, empathy, and understanding associated with longstanding personal relationships  
31 with their physicians. In recent times, however, corporate interests increasingly control the terms  
32 of access, including appointment availability and communication channels. Patients may still  
33 expect quick responses and timely care, even when physicians are facing staffing shortages,  
34 onerous bureaucratic demands, and contractual demands that often prioritize revenue over  
35 improved patient outcomes.

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<sup>8</sup> [https://jamanetwork.com/journals/jama/fullarticle/2813379?guestAccessKey=e0cef9be-d55c-4bcf-8892-412af8f24355&utm\\_source=For\\_The\\_Media&utm\\_medium=referral&utm\\_campaign=ftm\\_links&utm\\_content=tf&utm\\_term=122623](https://jamanetwork.com/journals/jama/fullarticle/2813379?guestAccessKey=e0cef9be-d55c-4bcf-8892-412af8f24355&utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_content=tf&utm_term=122623)

<sup>9</sup> <https://hms.harvard.edu/news/what-happens-when-private-equity-takes-over-hospital>

<sup>10</sup> <https://www.nejm.org/doi/10.1056/NEJMp2306904>

1 It is generally accepted that physicians have an ethical obligation to advocate on behalf of their  
2 patients. Whether advocating for regulatory change through public policy or institutional policies  
3 and practices, physicians are justified in participating in activities intended to improve patient  
4 safety and access.<sup>11</sup> With such significant changes to the practice environments in which  
5 physicians now find themselves, having a collective voice now seems understandable.

6 Organizations such as the AMA and ACP have recently shifted their policy language around  
7 collective bargaining to reflect the changes caused by the corporate practice of medicine and  
8 other influences on physician practice. The ACP uses the term “collective empowerment” to  
9 “describe actions that physicians may take, including advocacy, engaging the organized medical  
10 staff, and collective bargaining, to achieve better patient care, physician well-being, and other  
11 goals,” as collective bargaining is considered part of a larger picture of physician advocacy.<sup>12</sup> In  
12 addition, the AMA has added language to emphasize patient primacy when considering  
13 collective action, recognizing the increased interest in unionization by physicians.<sup>13</sup>

#### 14 **Collective Bargaining in the Practice of Medicine**

15 The NLRA has for 90 years protected the rights of workers to collectively bargain, participate in  
16 labor organizations, and take actions, such as strikes, in a legally protected manner. Under the  
17 NLRA, physicians may belong to a union if they are an employee in a non-supervisory position.  
18 In addition, the NLRA requires a 10-day staffing notice if physicians plan to strike or picket to  
19 allow time for staffing preparations.<sup>14</sup>

20 As more physicians practice as employees, rather than as contractors or business owners,  
21 union eligibility and participation have and continue to rise. However, the definition of “non-  
22 supervisory” practice remains contested, as it sometimes excludes positions such as medical  
23 directors or tenured medical faculty.<sup>15</sup> The AMA’s CEJA recently revised its policy to support  
24 narrowing the definition of “supervisor” under the NLRA to expand the number of physicians  
25 covered under the act.<sup>16</sup>

26 Some physician unions include the Committee of Interns and Residents (CIR), which is a  
27 branch of the Service Employees International Union (SIEU), the Union of American Physicians  
28 and Dentists, and Doctors Council. Resident unions such as CIR have been widely popular  
29 since 1957 and have attracted residents for a variety of reasons, such as fair pay, better work  
30 hours, housing benefits, mitigation of fatigue, retirement benefits, and childcare benefits.<sup>17,18</sup>  
31 Examples of resident union advocacy have included support for the 80-hour work week  
32 maximum, limits on on-call nights, and maternity leave benefits later codified by the

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<sup>11</sup> Fleming D. The Moral Agency of Physician Organizations: Meeting Obligations to Advocate for Patients and the Public. *Ann Internal Med.* 2015;163:918-921. Doi:10.7326/M15-2527

<sup>12</sup> <https://www.acpjournals.org/doi/10.7326/ANNALS-24-03973>

<sup>13</sup> <https://www.ama-assn.org/system/files/a25-ceja-reports.pdf>

<sup>14</sup> NLRA

<sup>15</sup> <https://www.ama-assn.org/system/files/a25-ceja-reports.pdf>

<sup>16</sup> <https://www.ama-assn.org/system/files/advocacy-issue-brief-physician-unions.pdf>

<sup>17</sup> <https://www.cirseiu.org/our-history/>

<sup>18</sup> <https://research.ebsco.com/c/ff3j6z/viewer/pdf/dihyblkclj>

1 Accreditation Council for Graduate Medical Education.<sup>19</sup> Approximately 27% of residents belong  
2 to a union, a significant increase from 10% in 2019.<sup>20</sup>

3 Non-resident physician unionization has also increased, with 7.2% of practicing physicians,  
4 compared to 5.7% in 2014.<sup>21</sup> Factors contributing to this trend may include stress and burnout  
5 as a result of the recent COVID-19 pandemic, increased corporate ownership in medicine, lack  
6 of independence in clinical decision-making, changes to the physician-patient relationship, and  
7 a rise in other conditions contributing to moral injury.<sup>22</sup>

8 In addition to increased membership in collective bargaining organizations in the United States,  
9 strike actions by physicians and physicians-in-training have been rising globally. Over the past  
10 several years, major physician strikes have occurred in the United Kingdom, South Korea,  
11 France, Michigan, New York, and Oregon.<sup>23</sup> These are often impacted by growing and  
12 constantly evolving issues that should be on the radar of all medical regulators. It is important  
13 for medical boards to be aware of these changes and to be prepared for their effects on  
14 physicians and patients alike.

## 15 **Considerations for Physicians**

16 Above all else, any collective bargaining efforts must put patients first and ensure continuity of  
17 care. The ACP prudently argues that "actions like a refusal to perform administrative  
18 requirements, billing duties, or concerted refusals to work should only be considered once all  
19 other negotiating tactics have been exhausted, and efforts have been made by all involved  
20 parties to ensure safe patient care."<sup>24</sup> It is not the sole responsibility of physicians to ensure  
21 continuation of care though they do have a primary obligation not to abandon care for their  
22 patients when leaving practice, whether permanently or temporarily, especially those most  
23 critical and otherwise vulnerable. Guided by decision-makers from a clinical perspective,  
24 institutions have a role to play in ensuring access to care and are responsible for implementing  
25 policies and procedures prioritizing patient safety and access, as well as seeking and hearing  
26 physician feedback regarding policies that impact patient care. Institutions should have plans in  
27 place to minimize or eliminate chances of disruptive actions, including, but not limited to,  
28 awareness of state labor laws, awareness of state medical or osteopathic practice acts,  
29 clarification of the purpose(s) of any disruptive action, and steps to maintain minimum staffing  
30 levels.

31 Physicians must also be wary of collective bargaining groups made up of members outside of  
32 healthcare. If joining in collective bargaining, physicians should ensure that the mission of the

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<sup>19</sup> <https://www.cirseiu.org/our-history/>

<sup>20</sup> <https://www.medscape.com/slideshow/Medscape-Residents-and-Unions-Report-2025-6018721>

<sup>21</sup> <https://www.ama-assn.org/system/files/advocacy-issue-brief-physician-unions.pdf>

<sup>22</sup> <https://www.acpjournals.org/doi/10.7326/ANNALS-24-03973>

<sup>23</sup> <https://pmc.ncbi.nlm.nih.gov/articles/PMC12067263/>

<sup>24</sup> <https://www.acponline.org/acp-newsroom/american-college-of-physicians-recommends-ways-physicians-can-be-more-effective-advocates-for>

1 group they are joining is similarly aligned with the professional mission and goals of physicians  
2 in advancing agendas that prioritize and protect patients.

### 3 **Considerations for State Medical Boards**

4 While related regulations and laws may vary across jurisdictions, it is clear that U.S. state and  
5 territorial medical boards have an important responsibility to protect the public and support  
6 access to safe, quality medical care. Any board actions regarding collective action should  
7 prioritize this goal. It is also important to consider that, from the medical regulatory perspective,  
8 employment conditions by themselves do not obviate the responsibilities inherent to the  
9 physician-patient relationship or compliance with standards for professional conduct. Physicians  
10 must uphold prevailing professional standards and be aware of what constitutes unprofessional  
11 conduct, including principles concerning patient abandonment and continuity of care. The  
12 Oregon Medical Board's (OMB) response to a physician strike in the state in 2024 provides an  
13 illustrative example. The board was approached by one of the state's hospital networks, which  
14 asked the OMB if it could help prevent physicians from going on strike by declaring that such  
15 conduct, were it to occur, was unprofessional and a violation of the state's Medical Practice Act.  
16 The OMB directed the hospital to reach out to its own legal resources to address the concerns  
17 of the physicians and promptly notified the governor's office and the OMB's attorney. Upon  
18 careful review of the AMA's Code of Ethics and the state medical practice act, the OMB  
19 determined that a physician strike would not, on its own, constitute "unprofessional conduct" in  
20 Oregon; however, if a complaint against a physician were to be filed with the OMB, it would be  
21 reviewed in full and acted upon only if appropriate. There was no legal vehicle to prevent the  
22 physicians from striking.

23 The affected hospitals also asked the OMB to reinstitute COVID-19 protocols by waiving the full  
24 license application for their locum tenens physicians. The OMB declined to do so but instead  
25 offered to expedite the processing of applications for these locums physicians, similar to the  
26 established procedure for rural applicants and for facilities with critical care needs in Oregon.  
27 The OMB ensured a 24-hour turnaround time on reviewing license applications.

28 Oregon Medical Board staff and leadership established direct lines of communication with  
29 hospital CMOs, were available on weekends, and committed to a 5-day license application  
30 approval. By the time that the physician strike ended after 46 days, the OMB had licensed  
31 approximately 40 locum tenens physicians for the hospital system, in some cases within 24  
32 hours of application receipt. The OMB did not intervene in the physician strike or negotiations  
33 protected by Oregon law and successfully upheld existing medical licensing policies,  
34 procedures, and standards. The focus from the beginning, according to its Executive Director,  
35 was on issuing licenses expeditiously and maintaining patient access to care for the duration of  
36 the work stoppage. Although the experience of the OMB is of a specific instance, the experience  
37 may help guide medical boards in future difficult cases.

### 38 **Conclusion**

39 The nature of physician employment has been rapidly changing in the United States, with many  
40 concerns raised for physicians, including tensions with corporate goals, increased bureaucratic  
41 requirements, eroding physician-patient relationships, and physician well-being. Physicians and

1 medical boards alike have the imperative to do whatever is within their means to protect patients  
2 and maintain continuity and access to quality care. Medical boards, specifically, should take  
3 actions as they deem appropriate to fulfill statutory duties of public protection and patient safety.  
4 This may include actions such as the ones taken by the Oregon Medical Board to preserve and  
5 facilitate access to care when that becomes necessary. Boards are encouraged to work within  
6 their own legal confines and with available resources to take any necessary action they deem  
7 appropriate for patient protection, preferably without taking a position in any bargaining dispute  
8 that may depart from the board's primary regulatory responsibilities.

9 In summary, state medical boards should consider:

- 10 1. Reviewing medical practice acts, rules, and regulations to clarify behavior that would  
11 potentially constitute "unprofessional conduct" in the context of strikes or collective  
12 actions, distinguishing lawful labor activities from conduct that might harm patients
- 13 2. Raising awareness among licensees regarding the board's expectations for licensees'  
14 professional conduct as related to participation in strikes or other collective actions.
- 15 3. Providing educational resources for licensees on ethically responsible participation in  
16 collective actions and strikes, including safeguards and potential consequences of  
17 compromising patient safety, continuity of care, and access.
- 18 4. Developing protocols for responding to anticipated or active strikes or other activities  
19 that may disrupt patient care. Protocols may include triage of inquiries or processes for  
20 monitoring potential impacts on patient access to care. These protocols should  
21 recognize applicable state and federal laws and regulations.
- 22 5. Preparing clear messaging and talking points for board staff in responding to questions  
23 from licensees, the public, media, and other interested and relevant parties in the event  
24 of strikes or other collective actions.

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1 **Members:**

2 Gerard "Gerry" Dillon, PhD, Committee Chair  
3 Pennsylvania Medical Board

4  
5 Andrea Anderson, MD, Med, FAAFP  
6 FSMB Board of Directors  
7 District of Columbia Medical Board

8  
9 Erin Cramer, PA-C  
10 Oregon Medical Board

11  
12 David Fleming, MD, MA, MACP (Subject Matter Expert)  
13 University of Missouri, Columbia School of Medicine

14  
15 Michelle Owens, MD  
16 Mississippi Medical Board

17  
18 Anuradha Rao-Patel, MD  
19 North Carolina Medical Board

20  
21 J. Michael Wieting, DO, MEd (Subject Matter Expert)  
22 Tennessee Osteopathic Medical Board

23  
24 Felix Yip, MD  
25 California Medical Board

26  
27 George Zachos, JD  
28 Massachusetts Medical Board

29  
30 **Ex Officio:**

31  
32 George Abraham, MD, MPH (FSMB Chair)  
33 Chair, FSMB Board of Directors  
34 Former Chair, Massachusetts Board of Registration in Medicine

35  
36 Christy Valentine Theard, MD, MBA  
37 Chair-elect, FSMB Board of Directors  
38 Former President, Louisiana State Board of Medical Examiners

39  
40 Humayun J. Chaudhry, DO, MACP  
41 President and CEO, FSMB

42  
43 **FSMB Staff Support:**

44  
45 Lisa Robin  
46 Chief Advocacy Officer, FSMB

47  
48 Calli Merron  
49 Policy Analyst, FSMB

50

**EXHIBIT**

**H**

**In re:**

**TIMOTHY JOHN RAMSDEN, M.D.,**

**Respondent.**

**BEFORE THE MEDICAL  
LICENSURE COMMISSION  
OF ALABAMA**

**STATEMENT OF CONTENTIONS**

Commissioner Craig H. Christopher, M.D., and the undersigned General Counsel, as the prosecution team established by Section 3 of the Order Setting Hearing, will contend that there exists “other good and reasonable cause for refusing to issue” an unrestricted license to Respondent to practice medicine and/or osteopathy in the State of Alabama within the meaning of Ala. Code § 34-24-333(a).

In particular, the Chairman and General Counsel contend that the following issues, facts, and circumstances are potential reasons for denying, restricting, probating, or otherwise conditioning the issuance of any such license:

1. In or about May 2021, the Florida Board of Medicine entered a Final Order approving and incorporating a Settlement Agreement between Respondent and the Florida Department of Health. The Settlement Agreement resolved claims alleged in an Administrative Complaint, alleging that Respondent improperly delegated laser hair removal treatments to an office manager, a Licensed Practical Nurse, and a medical assistant, when Respondent knew or should have known that

those persons were not qualified by training, experience, or licensure to perform those tasks.

2. The Settlement Agreement and Final Order required Respondent to complete an approved “laws and rules course,” and five hours of continuing medical education in “Risk Management,” and to pay fines and costs totaling \$3,225.91.

3. The Commission has probable cause to believe that the circumstances which led to Respondent’s entry into the Settlement Agreement and the Florida Board’s entry of the Final Order evidence that there exists “other good and reasonable cause for refusing to issue” an unrestricted license to Respondent to practice medicine and/or osteopathy in the State of Alabama within the meaning of Ala. Code § 34-24-333(a). The Commission intends at the hearing to inquire into the facts and circumstances of this matter.

4. In or about February 2023, Respondent entered into a Settlement Agreement (“the Settlement Agreement”) with the United States Department of Justice, Drug Enforcement Agency (“DEA”), in which Respondent agreed to pay the United States civil penalties totaling \$190,731.00, agreed to surrender his DEA registration for Schedule II and II-N controlled substances, and agreed not to reapply for Schedule II and II-N controlled substances for a period of five years (*i.e.*, through approximately February 2028).

5. Although the Settlement Agreement did not represent an admission of liability by Respondent, the DEA's allegations included at least the following:

- a. That Respondent failed to maintain complete and accurate records in accordance with 21 C.F.R. § 1304.21(a) and 21 U.S.C. § 827(a)(3), in violation of 21 U.S.C. § 842(a)(5) and punishable under 21 U.S.C. § 842(c)(1)(B)(i);
- b. That Respondent failed to document Beginning of Business (BOB) or Close of Business (COB) on the Biennial Inventory in accordance with 21 C.F.R. § 1304.11(a), in violation of 21 U.S.C. § 842(a)(5) and punishable under 21 U.S.C. § 842(c)(1)(B)(i);
- c. That Respondent failed to record the number of units or volume of each finished form in each commercial container on the biennial inventory in accordance with 21 C.F.R. § 1304.11(e)(6) referencing 21 C.F.R. § 1304.11(e)(1)(iii)(C), in violation of 21 U.S.C. § 842(a)(5) and punishable under 21 U.S.C. § 842(c)(1)(B)(i);
- d. That Respondent failed to indicate the date received on two (2) invoices in accordance with 21 C.F.R. § 1304.21(d), in violation of 21 U.S.C. § 842(a)(5) and punishable under 21 U.S.C. § 842(c)(1)(B)(i) for two separate violations;

- e. That Respondent failed to properly indicate the dispositions within the patient file in accordance with 21 C.F.R. § 1304.22(c), in violation of 21 U.S.C. § 842(a)(5) and punishable under 21 U.S.C. § 842(c)(1)(B)(i);
- f. That Respondent failed to document former APRN Totter's patient file where prescription #58778023 for Testosterone Enanthate (5 mL) Injectable was issued to Totter, in violation of 21 U.S.C. § 842(a)(5) and punishable under 21 U.S.C. § 842(c)(1)(B)(i); and
- g. That Respondent issued prescription #60472038 for 60 tablets of Oxandrolone to former APRN Totter on February 28, 2022, and mailed the prescription to Totter's residence, which was then returned to Respondent for Respondent's personal use. This practice violates 21 U.S.C. § 842(a)(1) and punishable under 21 U.S.C. §§ 842(c)(1)(A).

6. The Commission has probable cause to believe that the circumstances which led to Respondent's entry into the Settlement Agreement evidence that there exists "other good and reasonable cause for refusing to issue" an unrestricted license to Respondent to practice medicine and/or osteopathy in the State of Alabama within the meaning of Ala. Code § 34-24-333(a). The Commission intends at the hearing to inquire into the facts and circumstances of this matter.

7. The Commission intends to inquire into the details of Respondent's intended practice of medicine in Alabama, including, but not limited to, intended practice location, intended patient populations, intended scope of practice, intended therapies, whether and to what extent Respondent intends to delegate tasks to other providers, whether and to what extent Respondent intends to supervise such delegates, and whether and to what extent Respondent intends to use testosterone in females. The Commission also intends to inquire into whether, and/or to what extent, Respondent plans to treat male patients with potent anabolic steroids in Alabama, the perceived medical necessity of such treatments, and whether any other planned treatment of male patients in Alabama would be consistent with ACOG policies or recommendations.

8. Through these lines of questioning, the Commission will seek to be satisfied that all aspects of Respondent's practice will be legally compliant and consistent with good medical practice.

Respectfully submitted on this the 14th day of February, 2026.

By:

/s/ Aaron L. Dettling

Aaron L. Dettling  
General Counsel, Medical Licensure  
Commission of Alabama  
Fortif Law Partners, LLC  
o 205.832.9105  
c 205.515.4624  
2021 Morris Avenue, Suite 300  
Birmingham, Alabama 35203

**CERTIFICATE OF SERVICE**

I hereby certify that on February 14, 2026, I filed and served the foregoing document with the Medical Licensure Commission of Alabama in the manner prescribed in Section 7 of the Order Setting Hearing in this matter, as follows:

Dr. Timothy Ramsden  
The Anti-Aging Clinic of Northwest Florida  
13569 Panama City Beach Parkway  
Panama City Beach, Florida 32407  
obdoc63@msn.com

William R. Gordon  
Hearing Officer  
wrgordon@charter.net

Rebecca Robbins  
MLC Director of Operations  
rrobbins@almlc.gov

with a copy to:  
E. Wilson Hunter  
General Counsel  
Alabama Board of Medical Examiners  
whunter@albme.gov

/s/ Aaron L. Dettling  
Of Counsel

**ALABAMA STATE BOARD OF  
MEDICAL EXAMINERS,**

**Complainant,**

**vs.**

**STEVEN MITCHELL TAYLOR,  
M.D.,**

**Respondent.**

**EXHIBIT**

**I**

**BEFORE THE MEDICAL  
LICENSURE COMMISSION OF  
ALABAMA**

**CASE NO. 2025-597**

**CONSENT DECREE**

This matter comes before the Medical Licensure Commission of Alabama (“the Commission”) on the Administrative Complaint (“the Administrative Complaint”) filed by the Alabama State Board of Medical Examiners (“the Board”) on February 10, 2026. The Board and the Respondent, Steven Mitchell Taylor, M.D. (“Respondent”), have entered into a Joint Settlement Agreement (“the Settlement Agreement”), and have asked the Commission to approve the Settlement Agreement and to embody it in this Consent Decree.

**General Provisions**

1. **Approval of the Settlement Agreement.** After review, the Commission finds that the Settlement Agreement represents a reasonable and appropriate disposition of the matters asserted in the Administrative Complaint. The Commission therefore approves the Settlement Agreement.

2. **Mutual Agreement and Waiver of Rights.** Respondent has consented and agreed to the entry of this Consent Decree, and has agreed to be bound by the findings of fact, conclusions of law, and terms and conditions stated herein. Respondent has validly waived all rights to an administrative hearing before the Commission, to be represented by an attorney at such hearing, and to further notice and formal adjudication by the Commission of the charges arising from the Administrative Complaint. Respondent has also validly waived all rights to judicial review of this Consent Decree pursuant to Ala. Code § 34-24-367, the Alabama Administrative Procedure Act, Ala. Code §§ 41-22-1, *et seq.*, by extraordinary writ, or otherwise.

3. **Public Documents.** The Administrative Complaint, the Settlement Agreement, and this Consent Decree shall constitute public records under the laws of the State of Alabama. The Administrative Complaint, the Settlement Agreement, and this Consent Decree may be published or disclosed by the Board and/or the Commission without further notice to Respondent.

4. **Additional Violations.** Any violation of the requirements of this Consent Decree, or any new violation of state or federal laws or regulations, may result in the Board filing a petition to discipline Respondent's medical license. Nothing in this Consent Decree precludes the Board from bringing new

administrative charges against Respondent based upon events and circumstances not raised in the Administrative Complaint.

5. **Retention of Jurisdiction.** The Commission retains jurisdiction for the purpose of entering such other and further orders and directives as may be required to implement the provisions of this Consent Decree.

6. **Official Notice.** Pursuant to Ala. Code § 41-22-13(4), Respondent is informed that the Board and/or the Commission may at any time take official notice of this Consent Decree, and/or any of the Findings of Fact herein, and may deem any of the findings or conclusions set forth in this Consent Decree to be conclusively established, all without further notice to Respondent.

### **Findings of Fact**

1. Respondent has been licensed to practice medicine in the State of Alabama since June 23, 1999, having been issued license no. MD.22746. Respondent was so licensed at all relevant times.

2. Respondent is a vascular surgeon who practices at Alabama Vascular Solutions, located at 632 2nd Street NE, Alabaster, Alabama 35007.

3. At the relevant times, Respondent collaborated with Lindsey Smith, CRNP (“Smith”), who practiced at Hydra Health and Wellness (“Hydra”), located at 349 20th Street W, Jasper, Alabama, 35501. The collaboration between Respondent and Smith began on or about April 11, 2024.

4. At the relevant times, Hydra provided laser therapy pursuant to Smith's collaboration with Respondent. However, an audit conducted on July 31, 2025, revealed that Respondent did not hold a laser registration, which is required under Ala. Admin. Code r. 540-X-11-.13(1).

5. Respondent admits that his failure to obtain a laser registration constitutes a violation of Ala. Code § 34-24-360(23).

6. Respondent has terminated his collaboration agreement with Smith.

#### **Conclusions of Law**

1. The Commission has jurisdiction over the subject matter of the Administrative Complaint, and over the parties, pursuant to Ala. Code § 34-24-310, *et seq.*

2. The Commission finds, as a matter of law, that the determined facts constitute violations of Ala. Code § 34-24-360(23) and Ala. Admin. Code r. 540-X-11-.13(1).

#### **Order/Discipline**

Based upon the foregoing Findings of Fact and Conclusions of Law, it is ORDERED, ADJUDGED, AND DECREED:

1. That pursuant to Ala. Code § 34-24-381(a), Respondent is assessed an administrative fine in the amount of ten thousand dollars (\$10,000.00).

2. That pursuant to Ala. Code § 34-24-381(b), Respondent is assessed the Board's administrative costs in the amount of two thousand five hundred dollars (\$2,500.00).

3. In accordance with Ala. Admin. Code r. 545-X-3-.08(8)(d)(i), (10), Respondent is ordered to pay the foregoing assessed amounts, totaling twelve thousand five hundred dollars (\$12,500.00), within 30 days of this Order.<sup>1</sup>

DONE on this the 2nd day of March, 2026.

THE MEDICAL LICENSURE  
COMMISSION OF ALABAMA

By:

E-SIGNED by Jorge Alsip, M.D.  
on 2026-03-02 12:09:27 CST

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Jorge A. Alsip, M.D.  
its Chairman

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<sup>1</sup> See Ala. Admin. Code r. 545-X-3-.08(8)(d)(i). Respondent is further advised that “[t]he refusal or failure by a physician to comply with an order entered by the Medical Licensure Commission” may be a separate instance of “unprofessional conduct.” See Ala. Admin. Code r. 545-X-4-.06(6). Failure to timely pay the assessed costs and fines may therefore form an independent basis for further disciplinary action against Respondent.