



STATE OF WISCONSIN

Department of Safety and Professional Services
1400 E Washington Ave.
Madison WI 53703

Governor Scott Walker Secretary Dave Ross

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MEDICAL EXAMINING BOARD MEETING
Room 121A, 1400 E. Washington Avenue, Madison
DSPS Contact: Tom Ryan (608) 261-2378
SEPTEMBER 19, 2012

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

8:00 A.M.

OPEN SESSION

- 1. Call to Order – Roll Call**
- 2. Declaration of Quorum**
- 3. Introduction of New Board Member(s)**
- 4. Recognition of Board Member(s)**
- 5. Adoption of the Agenda (insert) (1-6)**
- 6. Approval of Minutes of August 15, 2012 (insert) (7-14)**
- 7. Case Presentations**

Presentation of Proposed Stipulation(s), Final Decision(s) and Order(s) in the Matter of:

- a. Paul E. Mannino, MD - 10 MED 170 **(205-214)**
 - Attorney Kim Kluck
 - Case Advisor – James Conterato
- b. Michael A. Ganz, MD – 11 MED 043 **(215-220)**
 - Attorney Kim Kluck
 - Case Advisor –Jude Genereaux
- c. Anatol Stankevych, MD – 11 MED 203 and 11 MED 231 **(221-230)**
 - Attorney Kim Kluck
 - Case Advisor – Kenneth Simons
- d. Javier A. Rincon, MD – 12 MED 004 **(231-238)**
 - Attorney Arthur Thexton
 - Case Advisor – LaMarr Franklin
- e. Bruce K. Jacobson, MD – 11 MED 415 **(239-244)**
 - Attorney Arthur Thexton
 - Case Advisor – LaMarr Franklin

- f. Ellen Blank, MD – 10 MED 383 **(245-252)**
 - o Attorney Pamela Stach
 - o Case Advisor – Sandra Osborn
- g. Behram Pastakia, MD – 11 MED 140 **(253-260)**
 - o Attorney Pamela Stach
 - o Case Advisor – Timothy Swan
- h. Rodrigo A. Castillo, MD 11 MED 245 **(261-268)**
 - o Attorney Pamela Stach
 - o Case Advisor – Gene Musser

8. Executive Director Matters

9. Items Received After Mailing of Agenda

- a. Presentation of Proposed Stipulations and Final Decisions and Orders
- b. Presentation of Proposed Decisions
- c. Presentation of Interim Orders
- d. Petitions for Re-hearing
- e. Petitions for Summary Suspension
- f. Petitions for Extension of Time
- g. Petitions for Assessments
- h. Petitions to Vacate Orders
- i. Requests for Disciplinary Proceeding Presentations
- j. Motions
- k. Appearances from Requests Received or Renewed
- l. Speaking Engagement, Travel and Public Relation Requests
- m. Application Issues
- n. Examination Issues
- o. Continuing Education Issues
- p. Practice Questions

10. Items for Board Discussion

- a. Consideration of Appointments to the Council on Anesthesiologist Assistants **(insert) (15-18)**
- b. FSMB Matters
 - 1. FSMB Board of Directors, Nominating Committee and other Committee Nominations **(insert) (19-34)**
- c. MTBT 1-7 Relating to Temporary Licensure and Continuing Education **(insert) (35-50)**
- d. Chapter MED 10 Discussion and Voting
 - 1. Informed Consent **(insert) (51-52)**
 - 2. Self Report Practice Limitations **(insert) (53-54)**
 - 3. Legislation to Amend Sec. 50.36(3) **(insert) (55-56)**
 - 4. Laws Related to Practice **(insert) (57-62)**
 - 5. Business Practices **(insert) (63-66)**
 - 6. Other Provisions **(insert) (67-70)**
 - 7. Other Provisions with WMS Suggested Language **(insert) (71-72)**
 - 8. Social Media **(insert) (73-90)**

9. Prescribing **(insert) (91-94)**
- e. Legislative Report
 1. Report from WMS Legislative Council Meeting, September 6, 2012 **(insert) (95-96)**
- f. Medical Board Newsletter
- g. Board Outreach/Speaking Engagements/Travel and Public Relation Requests
 1. Consider motion to authorize Mary Jo Capodice, DO, to attend the AAOE Meeting, October 8, 2012 in San Diego, CA. **(insert) (97-100)**
 2. Consider motion to authorize Legal Counsel Sandy Nowack to attend the FSMB Board Attorney Workshop, November 1-2, 2012 in New Orleans, LA. **(insert) (101-104)**

11. Screening Panel Report

12. Informational Item(s)

- a. Licensure Requirements for Anesthesiologist Assistants **(insert) (105-108)**
- b. MED 10 – Stakeholder Comments and Responses **(insert) (109-114)**
- c. MED 10 - Law Pertaining to Peer Review **(insert) (115-120)**
- d. MED 10 – *Journal Sentinel* Article on Physician Ethics in Social Media **(insert) (121-126)**
- e. CPEP Learning Summit **(insert) (127-130)**

13. Public Comment(s)

14. New/Other Business

CLOSED SESSION

CONVENE TO CLOSED SESSION to deliberate on cases following hearing (Wis. Stat. § 19.85 (1) (a)); consider closing disciplinary investigation(s) with administrative warning(s) (Wis. Stat. § 19.85 (1) (b), and Wis. Stat. § 440.205); consider individual histories or disciplinary data (Wis. Stat. § 19.85 (1) (f)); and to confer with legal counsel (Wis. Stat. § 19.85 (1) (g)).

CS-1 Full Board Oral Examination – APPEARANCE 10:30 A.M. – NANDA K. KAR, MD **(insert) (131-204)**

CS-2 Deliberation of Stipulation(s), Final Decision(s) and Order(s) in the Matter of:

- a. Paul E. Mannino, MD - 10 MED 170 **(insert) (205-214)**
 - o Attorney Kim Kluck
- b. Michael A. Ganz, MD – 11 MED 043 **(insert) (215-220)**
 - o Attorney Kim Kluck
- c. Anatol Stankevych, MD – 11 MED 203 and 11 MED 231 **(insert) (221-230)**
 - o Attorney Kim Kluck
- d. Javier A. Rincon, MD – 12 MED 004 **(insert) (231-238)**
 - o Attorney Arthur Thexton
- e. Bruce K. Jacobson, MD – 11 MED 415 **(insert) (239-244)**
 - o Attorney Arthur Thexton

- f. Ellen Blank, MD – 10 MED 383 **(insert) (245-252)**
 - o Attorney Pamela Stach
- g. Behram Pastakia, MD – 11 MED 140 **(insert) (253-260)**
 - o Attorney Pamela Stach
- h. Rodrigo A. Castillo, MD 11 MED 245 **(insert) (261-268)**
 - o Attorney Pamela Stach

CS-3 Deliberation of Proposed Decisions and Orders

- a. Amjad Butt, MD – 11 MED 340/DHA Case No. SPS-12-0025 **(insert) (269-278)**
- b. Anthony G. Peters, PA – 10 MED 299/DHA Case No. SPS-12-0024 **(insert) (279-290)**
- c. Chinelo S. Ude, MD – 11 MED 325/DHA Case No. SPS-12-0026 **(insert) (291-302)**
- d. Roger A. Pellman, MD – 09 MED 418/DHS Case No. SPS-09-0131 **(insert) (303-316)**

CS-4 Deliberation of Proposed Administrative Warning(s)

- a. 11 MED 234 (N.C., MD) **(insert) (317-318)**
 - o Attorney Kim Kluck
 - o Case Advisor – Kenneth Simons
- b. 11 MED 344 (D.P.B., MD) **(insert) (319-320)**
 - o Attorney Kim Kluck
 - o Case Advisor – Suresh Misra

CS-5 Consideration of Complaint(s)

- a. 12 MED 103 **(insert) (321-324)**

CS-6 Monitoring (insert) (325-326)

- a. Donald J. Hennessy, Jr, MD – Request for full licensure – **APPEARANCE 10:45 A.M. (insert) (327-372)**
- b. John W. Ingalls, MD – Request for full licensure **(insert) (373-386)**
- c. William G. Sybesma, MD – Request for full licensure **(insert) (387-582)**

CS-7 Case Closings (insert) (583-584)

CS-8 Consulting with Legal Counsel

Deliberation of Items Received in the Bureau after Preparation of Agenda

- a. Proposed Stipulations
- b. Proposed Decisions and Orders
- c. Proposed Interim Orders
- d. Objections and Responses to Objections
- e. Complaints
- f. Petitions for Summary Suspension
- g. Remedial Education Cases
- h. Petitions for Extension of Time
- i. Petitions for Assessments

- j. Petitions to Vacate Orders
- k. Motions
- l. Administrative Warnings
- m. Matters Relating to Costs
- n. Appearances from Requests Received or Renewed
- o. Examination Issues
- p. Continuing Education Issues
- q. Application Issues
- r. Monitoring Cases
- s. Professional Assistance Procedure Cases

Division of Enforcement – Meeting with Individual Board Members

Division of Enforcement – Case Status Reports and Case Closings

Ratifying Licenses and Certificates

RECONVENE INTO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION

Voting on Items Considered or Deliberated on in Closed Session if Voting is Appropriate

New/Other Business

ADJOURNMENT

1:15 PM

CLOSED SESSION

Examination of 9 (nine) Candidates for Licensure – Drs. Capodice, Musser, Osborn, Vasudevan

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**MEDICAL EXAMINING BOARD
MINUTES
AUGUST 15, 2012**

PRESENT: James Barr; Carolyn Bronston; Mary Jo Capodice, DO; Rodney Erickson, MD; Jude Genereaux; Gene Musser, MD; Sandra Osborn; Kenneth Simons, MD; Timothy Swan, MD; Sridhar Vasudevan, MD; Sheldon Wasserman, MD; Timothy Westlake, MD

EXCUSED: Suresh Misra, MD

STAFF: Tom Ryan, Executive Director; Sandra Nowack, Legal Counsel; Karen Rude-Evans, Bureau Assistant; other DSPS staff

GUESTS: Mark Grapentine and Michelle Leiker, Wisconsin Medical Society; Julie Doyle, Council on Physician Assistants; Charles Shabino and Laura Leitch, WHA; Scott Becher, Becher Group; Eric Jensen, WAPA; Jeremy Levin, RWHC; Bob Phillips, Marshfield Clinic, David Wahlberg, Wisconsin State Journal

CALL TO ORDER

Dr. Sheldon Wasserman, Chair, called the meeting to order at 8:00 a.m. A quorum of twelve (12) members was confirmed.

INTRODUCTION OF NEW BOARD MEMBERS

James Barr is the new public member.

RECOGNITION OF BOARD MEMBERS

MOTION: Sandra Osborn moved, seconded by Gene Musser, to send a letter to LaMarr Franklin to thank him for his service and dedication to the Board. Motion carried unanimously.

ADOPTION OF AGENDA

Amendments:

- Item 10d (open session) – Insert additional material after page 20
- Item 10e2 (open session) is removed from the agenda
- Item CS-5b (closed session) – Correct the case number to 11 MED 299
- Item CS-6a (closed session), Insert additional information after page 348
- Under DELIBERATION OF ITEMS RECEIVED AFTER PREPARATION OF THE AGENDA (closed session), Item I, insert – Petition for Mental Examination – 11 MED 315
- Case Status Report – insert at the end of the agenda in closed session

MOTION: Timothy Swan moved, seconded by Kenneth Simons, to adopt the agenda as amended. Motion carried unanimously.

APPROVAL OF MINUTES OF JULY 18, 2012

MOTION: Sandra Osborn moved, seconded by Timothy Swan, to approve the minutes of July 18, 2012 as written. Motion carried unanimously.

ITEMS FOR BOARD DISCUSSION

Wis. Admin. Code Chapter MED 10 Discussion and Voting

MOTION: Kenneth Simons moved, seconded by Carolyn Bronston that subject to technical legal revisions and review prior to public hearing, to accept the draft language as follows concerning wrong site surgery:

Performing any surgical or invasive procedure on the wrong patient, or at the wrong anatomical site or performing the wrong procedure on a patient.

Motion carried unanimously.

MOTION: Sridhar Vasudevan moved, seconded by James Barr, to authorize Sheldon Wasserman to work with Legal Counsel, the Wisconsin Hospital Association and the Wisconsin Medical Society to write motions for the September 19, 2012 Board meeting. Motion carried unanimously.

Legislative Report

- **Wis. Admin. Code POD Chs. 1 and 3 Relating To Podiatry Temporary Education Permit and Continuing Education**

MOTION: Sridhar Vasudevan moved, seconded by Sandra Osborn, to approve the proposed rule draft to Wis. Admin. Code POD Chs. 1 and 3 relating to a podiatry temporary education permit and continuing education. Motion carried unanimously.

Medical Examining Board Newsletter

MOTION: Kenneth Simons moved, seconded by Timothy Swan, to approve the newsletter as amended and to move forward and publish the newsletter. Motion carried unanimously.

Board Outreach

MOTION: Sandra Osborn moved, seconded by Sridhar Vasudevan, to approve Mary Jo Capodice to represent the Wisconsin Medical Examining Board at the American Association of Osteopathic Examiners (AAOE) Meeting on October 8, 2012 in San Diego, CA. Motion carried unanimously.

MOTION: Jude Genereaux moved, seconded by Kenneth Simons, to authorize Sridhar Vasudevan to represent the Wisconsin Medical Examining Board by offering his expertise and guidance to the Wisconsin Medical Society on its initiative concerning guidelines for opiate prescribing. This authorization does not include final approval by the Medical Examining Board of guidelines, policies or other instructional documents generated by the Wisconsin Medical Society. Motion carried unanimously.

SCREENING PANEL REPORT

Carolyn Bronston reported thirty seven (37) cases were screened. Ten (10) cases were opened and one (1) ten-day letter was sent.

RECESS TO CLOSED SESSION

MOTION: Sandra Osborn moved, seconded by Kenneth Simons, to convene to closed session to deliberate on cases following hearing (Wis. Stat. § 19.85 (1) (a)); consider closing disciplinary investigation(s) with administrative warning(s) (Wis. Stat. § 19.85 (1) (b), and Wis. Stat. § 440.205); consider individual histories or disciplinary data (Wis. Stat. § 19.85 (1) (f)); and to confer with legal counsel (Wis. Stat. § 19.85 (1) (g)). Roll call: James Barr-yes; Carolyn Bronston-yes; Mary Jo Capodice-yes; Jude Genereaux-yes; Gene Musser-yes; Sandra Osborn-yes; Kenneth Simons-yes; Timothy Swan-yes; Sridhar Vasudevan-yes; Sheldon Wasserman-yes; Timothy Westlake-yes. Motion carried unanimously.

Open session recessed at 11:35 a.m.

RECONVENE IN OPEN SESSION

MOTION: Sandra Osborn moved, seconded by Carolyn Bronston, to reconvene in open session. Motion carried unanimously.

Open session reconvened at 2:35 p.m.

ITEMS VOTED ON DURING CLOSED SESSION

FULL BOARD ORAL EXAMINATION

MOTION: Jude Genereaux moved, seconded by Gene Musser, to table the review of the application for licensure for **Sandra A. Sieck, MD**, pending receipt of successful completion of the Board Certification Examination; at which time full licensure will be granted. Motion carried. Sridhar Vasudevan opposed.

INTERVIEW FOR VISITING PROFESSOR LICENSE

MOTION: Sridhar Vasudevan moved, seconded by Carolyn Bronston, to grant a visiting professor license to **Charles H. C. Pilgrim, MD**, when all requirements are met. Motion carried. Kenneth Simons was excused during the interview and deliberation. Kenneth Simons and Sandra Osborn abstained.

PROPOSED STIPULATIONS, FINAL DECISIONS AND ORDERS

MOTION: Kenneth Simons moved, seconded by Carolyn Bronston, to adopt the Proposed Stipulation, Final Decision and Order in the disciplinary proceedings against **Edwin E. Ferguson, Jr., MD (11 MED 137)**. Motion carried. Sridhar Vasudevan abstained.

MOTION: Kenneth Simons moved, seconded by Timothy Swan, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against **Mark E. McDade, MD (11 MED 186)**. Motion carried. Jude Genereaux opposed.

MOTION: Kenneth Simons moved, seconded by Sandra Osborn, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against **Eileen M. Reardon, MD (09 MED 431)**. Motion carried unanimously.

MOTION: Sridhar Vasudevan moved, seconded by Timothy Westlake, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against **Gope Hotchandani, MD (11 MED 197)**. Motion carried unanimously.

MOTION: Sridhar Vasudevan moved, seconded by Carolyn Bronston, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Order in the disciplinary proceedings against **Mark D. Stannard, MD (11 MED 404)**. Motion carried unanimously.

PROPOSED ADMINISTRATIVE WARNING(S)

- MOTION:** Carolyn Bronston moved, seconded by Gene Musser, to issue the Administrative Warning in case **10 MED 146 against respondent N.H., MD.** Motion carried unanimously.
- MOTION:** Sridhar Vasudevan moved, seconded by Carolyn Bronston, to issue the Administrative Warning in case **11 MED 121 against respondent R.P.R., MD.** Motion carried 6 to 4.
- MOTION:** Sandra Osborn moved, seconded by Sridhar Vasudevan, to issue the Administrative Warning in case **11 MED 396 against respondent P.L.S., MD.** Motion carried unanimously.
- MOTION:** Gene Musser moved, seconded by Timothy Swan, to issue the Administrative Warning in case **11 MED 356 against respondent K.S.F., MD.** Motion carried unanimously.
- MOTION:** Gene Musser moved, seconded by Timothy Swan, to reject the Administrative Warning in case **12 MED 130 against respondent J.K.M., MD.** Motion carried 6 to 4.

CONSIDERATION OF COMPLAINT(S)

- MOTION:** Sandra Osborn moved, seconded by Carolyn Bronston, to find probable cause to issue a complaint in the matter of **11 MED 299.** Motion carried. Gene Musser abstained.

REQUEST FOR EQUIVALENCY OF ACGME APPROVED POST-GRADUATE TRAINING

- MOTION:** Timothy Swan moved, seconded by Rodney Erickson, to grant the request from **Abdelhafeez H. Abdelhafeez, MD,** for equivalency of the ACGME approved post-graduate training. Motion carried. Kenneth Simons was excused during deliberation and abstained. Sridhar Vasudevan opposed.

MONITORING

- MOTION:** Timothy Swan moved, seconded by Kenneth Simons, to grant the request from **Jennifer L. Nolden, PA,** for a reduction in drug screens to twenty four (24) per year with one (1) annual hair test. Motion carried unanimously.

MOTION: Kenneth Simons moved, seconded by Gene Musser, to grant the request from **Bradley J. Schingen, RCP**, for termination of the therapy requirement. Motion carried unanimously.

PETITION FOR MENTAL EXAMINATION

MOTION: Gene Musser moved, seconded by Kenneth Simons, to grant the Division of Enforcement's Petition for Mental Examination involving respondent **G.A. (11 MED 315)** and order that respondent G.A. undergo a neuropsychological evaluation. Motion carried unanimously. Legal Counsel Sandy Nowack was excused during deliberation and voting.

CASE CLOSINGS

MOTION: Carolyn Bronston moved, seconded by Kenneth Simons, to close case **11 MED 297 against respondents M.H., MD, R.H., MD, and C.R., MD, for no violation, and against respondent S.S., MD, for insufficient evidence.** Motion carried unanimously.

MOTION: Sridhar Vasudevan moved, seconded by Timothy Swan, to close case **12 MED 005 for insufficient evidence.** Motion carried unanimously.

MOTION: Kenneth Simons, moved, seconded by Gene Musser, to close case **12 MED 151 for no violation.** Motion carried unanimously.

MOTION: Sridhar Vasudevan, moved, seconded by Sandra Osborn, to close case **11 MED 238 for insufficient evidence.** Motion carried unanimously.

MOTION: Gene Musser, moved, seconded by Sandra Osborn, to close case **12 MED 189 against respondents T.J.O, MD, and P.K.D., PA-C, for no violation.** Motion carried unanimously.

MOTION: Carolyn Bronston, moved, seconded by Kenneth Simons, to close case **12 MED 094 for no violation.** Motion carried unanimously.

MOTION: Timothy Swan moved, seconded by Sandra Osborn, to close case **11 MED 290 for insufficient evidence.** Motion carried unanimously.

MOTION: Kenneth Simons moved, seconded by Timothy Swan, to close case **12 MED 024 for no violation.** Motion carried unanimously.

MOTION: Carolyn Bronston moved, seconded by Kenneth Simons, to close case **12 MED 054 for insufficient evidence.** Motion carried unanimously.

MOTION: Timothy Swan moved, seconded by Kenneth Simons, to close case **12 MED 130 for compliance gained.** Motion carried unanimously.

RATIFY ALL LICENSES AND CERTIFICATES

MOTION: Sandra Osborn moved, seconded by Carolyn Bronston, to ratify all licenses and certificates as issued. Motion carried unanimously.

ADJOURNMENT

MOTION: Kenneth Simons moved, seconded by Timothy Swan, to adjourn the meeting. Motion carried unanimously.

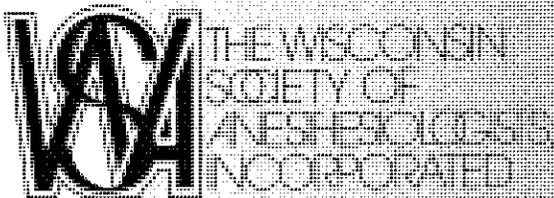
The meeting adjourned at 2:39 p.m.

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:	
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: September 19, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Consider Appointments to Council on Anesthesiologist Assistants	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing?	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Review list of names recommended for appointment by the Wisconsin Society of Anesthesiologists.			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	



September 6, 2012

Sheldon Wasserman, MD
Medical Examining Board
c/o Thomas Ryan
Department of Safety and Professional Services
PO Box 8935
Madison, WI 53708-8935

Dear Dr. Wasserman,

Below please find the names of the individuals and contact information the Wisconsin Society of Anesthesiologists (WSA) recommend for appointment to the AA Council as outlined in Section 1.15.407(7) of the statute:

(A) One Member of the Medical Examining Board:

Kenneth Simons, MD
The Eye Institute
925 N. 87th Street
Milwaukee, WI 53226
Phone: (414) 955-2020
Email: ksimons@mcw.edu

(B) One Anesthesiologist Assistant [Licensed under s.448.04 (1)(g)]:

Robert Stupi, AA-C
N7577 County Road XX
Holmen, WI 54636
Phone: 608-526-4694
Email: boband@centurytel.net

(C) Two Anesthesiologists :

Jay Mesrobian, MD
827 East Birch Ave.
Whitefish Bay, WI 53217
Phone: 414-614-4350
Email: jmesro@wi.rr.com

Carolyn Farrell, MD
5511 Tonyawath Trl
Madison, WI 53716
Phone: 608-575-1925
Email: weinhaus.wisc@att.net

(D) One Lay Member:

Marcy Salzer
141 Fredrick Ct.
Dousman, WI 53118
Phone: 414-647-3465
Email: marcy.salzer@aurora.org

Regards,

Lois A. Connolly, MD
President of the Wisconsin Society of Anesthesiologists

CC: Secretary Dave Ross

15.407 Same; councils.

(7) COUNCIL ON ANESTHESIOLOGIST ASSISTANTS; DUTIES. There is created a council on anesthesiologist assistants in the department of safety and professional services and serving the medical examining board in an advisory capacity. The council's membership shall consist of the following members, who shall be selected from a list of recommended appointees submitted by the president of the Wisconsin Society of Anesthesiologists, Inc., after the president of the Wisconsin Society of Anesthesiologists, Inc., has considered the recommendation of the Wisconsin Academy of Anesthesiologist Assistants for the appointee under par. (b), and who shall be appointed by the medical examining board for 3-year terms:

- (a)** One member of the medical examining board.
- (b)** One anesthesiologist assistant licensed under s. 448.04 (1) (g).
- (c)** Two anesthesiologists.
- (d)** One lay member.

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Department of Safety & Professional Services**

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3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: September 19, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? FSMB Board of Directors, Nominating Committee and Other Committee Nominations	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? (name) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Consider Board participation in FSMB leadership and committee possibilities.			
11) Authorization			
Signature of person making this request			Date
Supervisor (if required)			Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date

Ryan, Thomas - DSPS

From: Pamela Huffman (FSMB) [phuffman@fsmb.org] on behalf of Humayun Chaudhry [hchaudhry@fsmb.org]
Sent: Monday, August 27, 2012 7:44 AM
To: Pamela Huffman (FSMB)
Subject: FIRST Call for Nominations
Attachments: 1st Call for Nominations 08-27-12 REVISED (1).pdf
Importance: High

Dear Colleague,

FSMB Needs YOUR Leadership Skills.

One of the most rewarding experiences for members of state medical boards is the opportunity to serve on FSMB's Board of Directors or its Nominating Committee, helping guide our organization's vision and mission. Each year, FSMB's Nominating Committee seeks capable and committed individuals for consideration as candidates, and we would like to hear from you.

Service in a leadership position brings many benefits, notably the opportunity to make a real impact in the direction and policy of a national organization with a vital role in health care.

Nominations are open starting today, August 27, 2012, and will close January 7, 2013. Details regarding the nomination process are attached. We encourage you to make national service a part of your experience as an FSMB Fellow.

Sincerely,
Humayun J. Chaudhry, DO, FACP
President and CEO

Federation of State Medical Boards
400 Fuller Wiser Road | Suite 300 | Euless, TX 76039
817-868-4044 direct | 817-868-4144 fax



1912-2012 Celebrating 100 years of service, partnership, leadership, and innovation



DATE: August 27, 2012

TO: Active Fellows of the Federation and
Medical Board Executive Directors/Secretaries

FROM: Nominating Committee Chair Janelle A. Rhyne, MD, MA, MACP
Nominating Committee Members S. Paul Edwards, Esq., Mark A. Eggen, MD,
Jerry G. Landau, Esq., Geraldine T. O'Shea, DO, Louis E. Rosenthal, MD, and
Sheldon A. Wasserman, MD

RE: FIRST Call for Nominations of Candidates for Elective Office

Nominations of Candidates for Elective Office

Janelle A. Rhyne, MD, Chair of the FSMB's Nominating Committee, requests that Member Boards and Fellows of the FSMB submit names of individuals for the Nominating Committee to consider as candidates for elective office. Elections will be held at the FSMB's April 20, 2013 House of Delegates annual business meeting. Nominees may include physicians as well as non-physicians who are Fellows of the FSMB. The FSMB Bylaws state: *An individual member who as a result of appointment holds full time membership on a Member Medical Board shall be a Fellow of the FSMB during the member's period of service on a Member Medical Board, and for a period of 36 months thereafter.* Instructions for recommending candidates, including eligibility requirements with responsibilities of elected positions, are attached for your information. **Please refer to this information when submitting your letters of recommendation for consideration by the Nominating Committee.**

Under the FSMB Bylaws, the Nominating Committee must nominate one or more candidates for each position. Positions to be filled in 2013 are as follows:

- Chair-elect 1 Fellow, to be elected for 3 years: one year as chair-elect; one year as chair; and one year as immediate past chair
- Board of Directors 3 Fellows, each to be elected for a three-year term*
- Nominating Committee 3 Fellows, each to be elected for a two-year term**

The Nominating Committee requests that all recommendations for nominations be submitted by **January 7, 2013**. **No nominations will be accepted after January 7.**

***Should a current Director(s) on the Board, whose term is not scheduled to expire in 2013, be elected Chair-elect, then an additional Fellow(s) will be elected as a Director(s) to complete the unexpired term(s).**

****No two Nominating Committee members shall be from the same member board. Continuing members of the Committee will be from Arizona Osteopathic, Minnesota and Wisconsin.**

INSTRUCTIONS FOR RECOMMENDING CANDIDATES FOR NOMINATION TO FSMB ELECTED POSITIONS

Eligibility

Any person who is or will be a Fellow of the FSMB at the time of the election on April 20, 2013 is eligible for nomination. The Bylaws of the FSMB define Fellows as: *An individual member who as a result of appointment holds full time membership on a Member Medical Board shall be a Fellow of the FSMB during the member's period of service on a Member Medical Board, and for a period of 36 months thereafter.*

Core Competencies of Candidates

A candidate for elective office should:

- Support the vision, mission, values and strategic goals of the FSMB;
- Possess a positive outlook on the role and function of state medical boards in the medical regulatory field;
- Bring a broad, national perspective to specific issues;
- Have adequate time and commitment necessary to fulfill the responsibilities of the office (*please see attached "Responsibilities of Elected Positions"*);
- Demonstrate personal integrity.

Letter of Recommendation - Contents

The letter of recommendation to the Nominating Committee should specify (1) the name of the candidate to be considered; (2) the office for which the candidate is being recommended; (3) a description of the candidate's ability to demonstrate the core competencies as stated above; (4) the candidate's agreement to the submission of his/her name for potential nomination; (5) the candidate's affirmation that he/she is aware of the time commitment required for the position to which he/she may be elected; and (6) the candidate's mailing address, daytime telephone number, fax number and email address.

Attachments to Letter of Recommendation

The following materials should accompany the letter of recommendation:

1. **Candidate's General Information Questionnaire (attached).** In the interest of uniformity and fairness to all candidates, the Nominating Committee requests that the information contained on the Candidate's General Information Questionnaire be limited to the space provided, *except where otherwise stated.*
2. **Signatory Form (attached).** The candidate must submit a signed confirmation that the candidate 1) will be a Fellow as defined by the FSMB Bylaws at the time of the election on Saturday, April 20, 2013; 2) is aware of the time commitment required for the position to which he/she may be elected; and 3) is disclosing any potential conflict(s) of interest.
3. **Candidate's photograph – color or black/white.** Copies of the photos will be included in the Nominating Committee meeting agenda book. If the nominee is selected, the photos will also be used in the Election Manual that is distributed at the Annual Meeting and placed on the Candidates Website. **Questions regarding photos should be directed to David Hooper, Sr. Director of Marketing, at 817-868-4070 or dhooper@fsmb.org.**
4. **Personal statement by the candidate (sample attached) – an electronic copy no greater than 500 words.** The candidate should state why he/she wants to serve in the particular position in which he/she will be campaigning for election; how he/she fulfills the core competencies of candidates, and what he/she will

contribute to FSMB. The personal statement will be included in the Election Manual and placed on the Candidates Website.

5. ***Electronic copy of the candidate's curriculum vitae (CV) (a maximum of five pages) and a one-page bio or summary CV.*** Please provide relevant information including important appointments, honors and awards received, etc. **Please note that these documents will be published on the Candidates Website; therefore, social security numbers and all other private information must be removed prior to forwarding with letters of recommendation.**

Deadline for Submission of Letters and Materials

The members of the Nominating Committee request that all recommendations for nominations be submitted in writing by mail, fax or email to:

Janelle A. Rhyne, MD, Chair
Nominating Committee
c/o Pat McCarty, Director of Leadership Services
Federation of State Medical Boards
400 Fuller Wiser Road, Suite 300
Euless, TX 76039-3855
Fax: (817) 868-4167
Email: pmccarty@fsmb.org

The National Office should receive letters and accompanying materials by **January 7, 2013**. **No nominations will be accepted after January 7.**

A confirmation acknowledging receipt of nominations will be sent within one week. If you do not receive confirmation, please contact Pat McCarty at (817) 868-4067 or at the email above.

RESPONSIBILITIES OF ELECTED POSITIONS

Board of Directors

The FSMB Board of Directors is responsible for the control and administration of the FSMB and reports to the House of Delegates; the Board provides leadership in the development and implementation of the FSMB's Strategic Goals and the Board's Annual Action Plan; the Board is responsible for governing and conducting the business of the corporation, including supervising the President/CEO; and, under the leadership of the Chair and President/CEO, represents the FSMB to other organizations and promotes recognition of the FSMB as the premier organization concerned with medical licensure and discipline. The Board of Directors is the fiscal agent of the corporation.

GENERAL RESPONSIBILITIES

The Board of Directors is responsible for the following:

1. Set goals, objectives and priorities necessary to achieve the FSMB Strategic Goals.
2. Set goals, objectives and critical success factors for the President/CEO.
3. Ensure effective management of the FSMB's financial resources.
4. Approve systems for assessing and addressing needs of member boards.
5. Implement adopted Board of Directors professional development and self-assessment plans.
6. Promote use of FSMB services among targeted customer groups.
7. Enhance communication with and among member boards.
8. Enhance support and education for member board executives and their staff.

TIME COMMITMENT

The Board of Directors will meet five times during the 2013-2014 fiscal year:

- April 21, 2013 – Boston, MA (immediately following the Annual Meeting)
- July 2013 – site and actual dates TBD
- October 2013 – site and actual dates TBD
- February 2014 – site and actual dates TBD
- April 22-27, 2014 – Denver, CO (in conjunction with the Annual Meeting)

The dates above include travel days.

Nominating Committee

COMMITTEE CHARGE

The charge of the Nominating Committee as currently set forth in the FSMB Bylaws is to submit a slate of one or more nominees for each of the offices and positions to be filled by election at the Annual Meeting of the House of Delegates. The Committee will mail its slate of candidates to Member Boards not fewer than 60 days prior to the meeting of the House of Delegates.

Tasks of the Committee include:

1. Soliciting recommendations for candidates for elected positions from Member Boards and Fellows of the FSMB.
2. Assertively recruiting individuals who have the core competencies set forth on page 2 and who represent diversified backgrounds, experiences and cultures.
3. Educating potential candidates on core competencies for FSMB leadership roles and the responsibilities associated with respective leadership positions.
4. Reviewing letters of recommendation and supporting material of each individual nominated or recruited as a candidate for election.
5. Verifying that candidates have the core competencies for FSMB leadership positions.
6. Verifying that queries of FSMB Board Action Data Bank have been completed on physician candidates and that no actions have been reported which could call into question an individual's fitness for FSMB leadership.
7. Affirming that all candidates for elected leadership have disclosed any potential conflicts of interests.
8. Considering the importance of public representation on the FSMB Board of Directors and assuring the slate of candidates provides for election of adequate/qualified public representation.
9. Selecting and narrowing the slate of candidates to those who best demonstrate the core competencies; have the necessary qualifications and eligibility for a position; and bring valuable talents and perspectives to the FSMB.
10. Preparing a report to the House of Delegates that includes a slate of nominees for positions to be filled by election at the House of Delegates annual business meeting.
11. Determining process for notifying candidates of the Nominating Committee's decisions as soon as possible following the Committee meeting and providing the Nominating Committee report to the FSMB Board of Directors.

TIME COMMITMENT

Members of the Nominating Committee serve two-year terms. The Committee will have its kick-off session in Boston, MA on the morning of Sunday, April 21, 2013 directly after the FSMB's Annual Meeting. The Committee will meet again via teleconference in July or August 2013 (date to be determined) and in Euless, Texas in January 2014.

CANDIDATE'S GENERAL INFORMATION QUESTIONNAIRE

*PLEASE TYPE OR PRINT AND LIMIT YOUR INFORMATION TO THE SPACE PROVIDED
(except where otherwise stated)*

<i>GENERAL</i>	
NAME:	_____
CANDIDATE FOR:	_____
MAILING ADDRESS:	_____ _____
DAYTIME TELEPHONE:	_____
EMAIL AND/OR FAX:	_____

<i>EDUCATION</i>	
UNDERGRADUATE:	_____
MEDICAL SCHOOL/GRADUATE SCHOOL:	_____ _____
POSTGRADUATE EDUCATION:	_____ _____
CURRENT POSITION:	_____
AREA OF SPECIALIZATION:	_____

<i>FEDERATION ACTIVITIES</i>	
BOARD and/or COMMITTEES:	_____ _____ _____
OTHER FSMB ACTIVITIES:	_____ _____ _____

CANDIDATE SIGNATORY PAGE

STATE MEDICAL BOARD ACTIVITIES

On which state medical board are you currently serving?

If not serving, when did you leave the board? Month _____ Day _____ Year _____

How long have you served (did you serve) on your state medical board?

- I will be a Fellow as defined by the FSMB Bylaws at the time of the election on Saturday, April 20, 2013 and understand that only an individual who is a Fellow at the time of the individual's election shall be eligible for election. The Bylaws of the FSMB defines Fellow as:
An individual member who as a result of appointment holds full time membership on a Member Medical Board shall be a Fellow of the FSMB during the member's period of service on a Member Medical Board, and for a period of 36 months thereafter.
- I am aware of the time commitment for the position I wish to be elected.
- I am disclosing any potential conflict(s) of interest.

SIGNATURE: _____

Potential Conflict(s) of Interest

SAMPLE PERSONAL STATEMENT [500 words or less]

NAME: _____

CANDIDATE FOR: [Chair-elect, Board of Directors or Nominating Committee]

[SAMPLE TEXT – please describe your own experiences using your own words]

I am a candidate for [elective office]. Since beginning my medical career in a small rural town over 20 years ago, I have been involved in professionalism and upholding the higher standards of being a physician. Currently, I am the Chairman of the Department of [specialty] at the School of Medicine in [city].

My experiences with medical licensure began in the 90's when I was appointed to the advisory committee for athletic trainers of the [state medical board]. Subsequently, I was appointed as a member of the [state medical board] in 2009. I was elected Vice President in 2010 and have been serving as President since 2011.

Since being appointed to the [state medical board], I have been serving the [state medical board] in a number of capacities, which have included [committee/workgroups, etc.].

Additionally, I have worked as [other professional experiences and associations].

It is with great anticipation that I am running for [elective office]. I have the energy, enthusiasm and experience to represent the FSMB. My qualifications are broad and strong, which will allow me to function well within a system that is focused on licensure, discipline and protection of the public.

Ryan, Thomas - DSPS

From: Pamela Huffman (FSMB) [phuffman@fsmb.org] on behalf of Humayun Chaudhry [hchaudhry@fsmb.org]
Sent: Monday, August 27, 2012 7:46 AM
To: Pamela Huffman (FSMB)
Subject: FIRST Call for Committee Appointments
Attachments: Committee Responsibilities 2012.pdf

Importance: High

Dear Colleague:

Following the 2013 Annual Meeting, FSMB's incoming Chair, Jon Thomas, MD, will finalize appointments to the Audit, Bylaws, Editorial, Education, Ethics and Professionalism, and Finance Committees, and potentially to an FSMB Special Committee(s).

Committee responsibilities and time commitments vary, but to complete their charges successfully, all committees require dedicated and knowledgeable members. To begin the appointment process, individuals interested in serving on a committee, or those wishing to recommend an individual, should submit letters of interest/recommendation by **January 7, 2013** via mail, fax or email to:

Jon Thomas, MD, Chair-elect
Federation of State Medical Boards
c/o Pat McCarty, Director of Leadership Services
400 Fuller Wiser Road, Suite 300
Eules, Texas 76039-3855
Fax: (817) 868-4167
Email: pmccarty@fsmb.org

Additionally a copy of the individual's CV (a maximum of five pages) and/or biographical sketch, including state medical board and/or FSMB experience, should be forwarded to the email above accompanied by a **photograph – color or black/white (jpg is preferred but hard copies are acceptable)**. Copies of the photos will be included with the materials Dr. Thomas will be reviewing as he considers his appointments. Those appointed to committees also will have their photos posted on the FSMB website.

A confirmation acknowledging receipt of appointment recommendations will be sent within one week. If you do not receive confirmation, please contact Pat McCarty at (817) 868-4067 or by email.

Sincerely,
Humayun J. Chaudhry, DO, FACP
President and CEO

Federation of State Medical Boards
400 Fuller Wiser Road | Suite 300 | Eules, TX 76039
817-868-4044 direct | 817-868-4144 fax

FEDERATION OF STATE MEDICAL BOARDS
Responsibilities of Appointed Positions

Audit Committee

COMMITTEE CHARGE

The primary charge of the Audit Committee, as currently set forth in the FSMB Bylaws, Article VIII, Section B, is to review the audit of the corporation and the accompanying financial statements.

Tasks of the Committee include:

1. Reviewing the auditor's report with particular attention to material deficiencies and recommendations.
2. Reviewing the annual Statement of Financial Position, Statement of Activities and Statement of Cash Flows resulting from the audit process.

TIME COMMITMENT

Members of the Audit Committee serve one-year terms. Due to advances in technology and common practice of audit committees within the U.S., the Audit Committee traditionally meets via teleconference two to four times during the year, with the potential for one face-to-face meeting.

Bylaws Committee

COMMITTEE CHARGE

The charge of the Bylaws Committee, as currently set forth in the FSMB Bylaws, Article VIII, Section C, is to continually assess the Articles of Incorporation and the Bylaws and receive all proposals for amendments thereto. The Committee will, from time to time, make recommendations to the House of Delegates for changes, deletions, modifications and interpretations to the Bylaws.

Tasks of the Committee include:

1. Receiving requests for amendments or revisions from the Board of Directors or from Member Boards. Upon receiving requests, the Committee drafts Bylaws language that is appropriate in style and placement. The Bylaws Committee members may also propose amendments or revisions to the Bylaws, and draft language that is appropriate for inclusion.
2. Advising the House of Delegates with regard to each modification they have drafted, citing in their report to the House their choice to support, oppose or remain neutral regarding the language they have drafted. Members of the Committee may give testimony in support of their position before a Reference Committee.
3. Interpreting the Bylaws upon request of the Board of Directors, Member Boards or others.
4. Reviewing the Bylaws and Articles of Incorporation on a continual basis.

TIME COMMITMENT

Members of the Bylaws Committee serve one-year terms. The Committee will meet once by teleconference or as many times as is needed.

Editorial Committee

COMMITTEE CHARGE

The charge of the Editorial Committee, as currently set forth in the FSMB Bylaws, Article VIII, Section D, is to advise the Editor-in-Chief on editorial policy for the FSMB's official publication (*Journal of Medical Regulation*) and otherwise assist the Editor-in-Chief in the performance of duties as appropriate and necessary.

Tasks of the Committee include:

1. Reviewing all articles submitted for publication in a timely manner.
2. Supplying the names of at least two authors (four is preferred) who are able to write an article(s) for the *Journal*.
3. Writing or working with the *Journal* Editor-in-Chief to create an editorial for the *Journal*.
4. Serve as ongoing ambassadors for the *Journal* during any appropriate business meetings or discussions with colleagues — distributing the PDF Call for Papers in printed or electronic form whenever and wherever appropriate.

TIME COMMITMENT

Members of the Editorial Committee serve three-year terms. The Committee will meet once each year at FSMB headquarters or other location and will also meet via teleconference two to four times each year. The Committee will also be asked to read manuscripts throughout the year.

Education Committee

COMMITTEE CHARGE

The charge of the Education Committee as currently set forth in the FSMB Bylaws, Article VIII, Section E is to assist in the development of educational programs for the FSMB. This includes the Annual Meeting program as well as webinars, teleconferences and other educational offerings.

Tasks of the Committee include:

1. Providing consultation and recommendations in the development and review of the FSMB's annual education agenda.
2. Identifying and prioritizing educational topics in accordance with the mission, vision, core values and goals of the FSMB.
3. Evaluating education trends and opportunities to provide quality educational programming to FSMB membership.

TIME COMMITMENT

Members of the Education Committee serve one-year terms. The Committee will meet several times per year either in person or via teleconference. The frequency of regular meetings will be determined by need, but will occur at least quarterly.

Ethics and Professionalism Committee

COMMITTEE CHARGE

The charge of the Ethics and Professionalism Committee as currently set forth in the FSMB Bylaws, Article VIII, Section F is to address ethical and professional issues pertinent to medical regulation.

TIME COMMITMENT

Members of the Ethics and Professionalism Committee serve one-year terms. The Committee will meet several times per year either in person or via teleconference. The frequency of regular meetings will be determined by need.

Finance Committee

COMMITTEE CHARGE

The charge of the Finance Committee as currently set forth in the FSMB Bylaws, Article VIII, Section G is to review the financial condition of the FSMB, review and evaluate the costs of the activities and/or programs to be undertaken in the forthcoming year, and recommend a budget to the Board of Directors for its recommendation to the House of Delegates at the Annual Meeting, and perform such other duties as are assigned to it by the Board of Directors.

Tasks of the Committee include:

1. Assessing prior financial performance in comparison to budget.
2. Reviewing the draft budget for alignment with organizational goals, programs and services.
3. Approving the budget for recommendation to the Board of Directors.

TIME COMMITMENT

Members of the Finance Committee serve one-year terms. The Committee will meet several times per year either in person or via teleconference. The frequency of regular meetings will be determined by need.

Special Committees

Special Committees are appointed by the Chair as necessary and are established for a specific purpose. Special Committees usually meet three times per year, in person and via teleconference, and continue their work for about two years. Special Committees for 2013-2014 are to be determined.

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**State of Wisconsin
Department of Regulation and Licensing**

AGENDA REQUEST FORM

Name and Title of Person Submitting the Request: Shawn Leatherwood, Division of Board Services on behalf of Sandy Nowack		Date When Request Submitted: September 5, 2012
		Items will be considered late if submitted after 5 p.m. and less than: ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before meeting for all other boards
Name of Board, Committee, Council: Medical Examining Board		
Board Meeting Date: 09/19/12	Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	How should the item be titled on the agenda page? Wis. Admin. Code MTBT 1-7 relating to Temporary licensure and continuing education
Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	Is an appearance before the Board being scheduled? If yes, by whom? Yes by _____ (name) <input checked="" type="checkbox"/> No	Name of Case Advisor(s), if required: N/A
Describe the issue and action the Board should address: The Massage Therapy and Bodywork Therapy Affiliated Credentialing Board, pursuant to s. 15.085(b)1, Stats., submits this propped rule draft for the Medical Examining Board's review and comment. The MEB may make recommendations for the MTBT Board's consideration. Review must occur at least 60 days before the rule draft is submitted to the legislative council staff per s. 225.15 (1), Stats.		
If this is a "Late Add" provide a justification utilizing the Agenda Request Policy:		
<p>Directions for including supporting documents:</p> <ol style="list-style-type: none"> 1. This form should be attached to any documents submitted to the agenda. 2. Documents submitted to the agenda must be single-sided. 3. Only copies of the original document will be accepted. 4. Provide original documents needing Board Chairperson signature to the Bureau Director or Program Assistant prior to the start of a meeting. 		
Authorization:		
<i>Shancethea N. Leatherwood</i>		12/05/12
Signature of person making this request		Date
Supervisor signature (if required)		Date
Bureau Director signature (indicates approval to add late items to agenda)		Date

STATE OF WISCONSIN
MESSAGE THERAPY AND BODYWORK THERAPY
AFFILIATED CREDENTIALING BOARD

IN THE MATTER OF RULE-MAKING : PROPOSED ORDER OF THE
PROCEEDINGS BEFORE THE : MESSAGE THERAPY AND
MESSAGE THERAPY AND BODYWORK : BODYWORK THERAPY AFIILIATED
THERAPY AFFILIATED CREDENTIALING: CREDENTIALING BOARD
BOARD : ADOPTING RULES
:(CLEARINGHOUSE RULE)

PROPOSED ORDER

An order of the Massage Therapy and Bodywork Therapy Affiliated Credentialing Board to amend MTBT 1.01, 2.01 (title), 2.03 (title), 2.03 (1) (a), 2.03 (c), 2.05 (title) (intro) 2.05 (3), 2.05 (5), 2.05 (7), 3.01 (1), 3.01 (5) (b), 4.01 (title) (intro), 4.02(title) (intro), 4.02 (1), 4.02 (3), 4.03, 4.04 (1), 4.04 (1)(a), 4.04 (1) (c), 5.01 (9), 5.01 (16), 5.01 (17), 5.01 (18), 5.01 (20), 5.01 (27), 5.01 (28), 5.01 (32), 5.02 (1), 5.02 (2) (b), 5.02 (2) (c), 5.02 (3), 5.02 (4); repeal and recreate MTBT 1.02; to create MTBT 6.01, 6.02, 7.01, 7.02, and 7.03. relating to temporary licensure and continuing education.

Analysis prepared by the Department of Safety and Professional Services.

ANALYSIS

Statutes interpreted:

Sections. 460.04(2) (a), 460.04 (2) (f), 460.04 (2) (c), 460.11 (1), 460.04 (2) (d), 460.11(3), and 460.08, Stats and 2009 Wisconsin ACT 355

Statutory authority:

Sections 460.04 (2), 460.04 (2)(f), 460.10 (1), Stats.

Explanation of agency authority:

Affiliated credentialing boards are generally empowered by the legislature pursuant to s. 15.085 and 440.035 (1), Stats. to promulgate rules that govern their profession. The Massage Therapy and Bodywork Therapy Affiliated Credentialing Board has been specifically empowered by recent legislation to promulgate rules concerning temporary licenses, continuing education and standards that govern the professional conduct of license holders pursuant to s. 460.04 (2) and 2009 Wisconsin Act 355. Therefore, the Massage Therapy and Bodywork Therapy Affiliated Credentialing Board is authorized both generally and specifically to promulgate the proposed rules.

Related statute or rule:

Wis. Admin. Code Chapter MTBT 2 to 4

Plain language analysis:

2009 Wisconsin Act 355 transformed the Massage Therapy and Bodywork Therapy Council into the Massage Therapy and Bodywork Therapy Affiliated Board. (Board) The newly formed board functions under the oversight of the Medical Examining Board. The Board was granted rule making authority by the legislature and may now grant licenses instead of certificates. The proposed rule carries out the intent of the legislature by making the necessary changes to Wis. Admin. Code MTBT 1 - MTBT 5 and creating MTBT 6 and MTBT 7. The necessary changes include defining terms such as informed consent, intimate parts, sexually oriented business, and setting forth the requirements for temporary licensure and continuing education.

SECTION 1. amends the authority section by replacing department with board.

SECTION 2. repeals and recreates the definition section to include additional terms.

SECTION 3. amends title of MTBT 2.01 to replace certificate with license.

SECTION 4. amends the title of MTBT 2.03 replacing certificate with license.

SECTION 5. amends the title of MTBT 2.05 replacing certificate with license.

SECTION 6. amended the section by replacing department with board and certificate with license.

SECTIONS 7. To 12. Replaced department with board and certificate with licensure.

SECTION 13. creates provisions regarding temporary licensure.

SECTION 14. creates provisions regarding continuing education.

Summary of, and comparison with, existing or proposed federal regulation:

None

Comparison with rules in adjacent states:

Illinois:

Illinois regulates massage therapy via the Massage Licensing Act. Ill. Admin. Code tit.68 §1284 (2012) Illinois exempts students from the licensure requirement as long as they are practicing in conjunction with an approved massage school or program. Approved

Related statute or rule:

Wis. Admin. Code Chapter MTBT 2 to 4

Plain language analysis:

2009 Wisconsin Act 355 transformed the Massage Therapy and Bodywork Therapy Council into the Massage Therapy and Bodywork Therapy Affiliated Board. (Board) The newly formed board functions under the oversight of the Medical Examining Board, may grant licenses instead of certificates, and was granted rule making authority by the legislature. The proposed rules carries out the intent of the legislature by making the necessary changes to Wis. Admin. Code MTBT 1 - MTBT 5. The necessary changes include defining terms such as informed consent, intimate parts, sexually oriented business, and setting forth the requirements for temporary licensure and continuing education.

SECTION 1. amends the authority section by replacing department with board.

SECTION 2. repeals and recreates the definition section to include additional terms.

SECTION 3. amends title of MTBT 2.01 to replace certificate with license.

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SECTION 5. amends the title of MTBT 2.05 replacing certificate with license.

SECTION 6. amended the section by replacing department with board and certificate with license.

SECTIONS 7. To 12. Replaced department with board and certificate with licensure.

SECTION 13. creates provisions regarding temporary licensure.

SECTION 14. creates provisions regarding continuing education.

Summary of, and comparison with, existing or proposed federal regulation:

None

Comparison with rules in adjacent states:

Illinois:

Illinois regulates massage therapy via the Massage Licensing Act. Ill. Admin. Code tit.68 §1284 (2012) Illinois exempts students from the licensure requirement as long as they are practicing in conjunction with an approved massage school or program. Approved

massage therapy schools are required to meet certain criteria including maintaining written programs, written plans of study, written course outlines and student handbooks. Applicants are required to obtain 500 hours of supervised hands-on instruction from an approved massage therapy school. Ill. Admin. Code tit. 68 §1284.20 With regards to continuing education 24 hours are required per biennium. Illinois does not issue a temporary license

Iowa:

Iowa regulations encompass both massage and bodywork therapy. IA. r. 645-131.1 Iowa requires "500 hours in massage therapy education" for licensure. IAC r. 645-131.3 Furthermore, Iowa only allows temporary licensure for applicants from other states with less stringent licensure criteria. IAC 131-5 (1) Students are not exempt from the licensure requirement. However, students may participate in "clinical practicum," meaning, "hands-on" massage therapy provided to members of the public," at the massage therapy school's primary location which is similar to an on-site student clinic. Lastly, Iowa requires 24 hours of continuing education per biennium.

Michigan:

Michigan regulates massage therapy by statute under MCL 333.17591-333.17969 (2012). Administrative rules are pending as of December 19, 2011. The practice act defines such terms as "massage therapist," and "practice of massage therapy." The terms bodywork or body worker are not included. 18 hours of continuing education are required by statute. There are no provisions for temporary licensure. The Michigan practice act allows students to practice massage therapy as a part of program of study if they are enrolled in school and under the supervision of a licensed massage therapist.

Minnesota:

Massage and bodywork therapist are not licensed, certified, or registered in Minnesota. Minnesota maintains general oversight of the practice of massage therapy and bodywork through Minn. Stat. §146A, (2011)The Unlicensed Complementary and Alternative Health Care Practice Act. This act identifies body work, massage, and massage therapy as encompassed within the, "broad domain of complementary and alternative healing methods and treatment".

Summary of factual data and analytical methodologies:

The Massage Therapy and Bodywork Therapy Affiliated Credentialing Board ensured the accuracy, integrity, objectivity and consistency of data were used in preparing the proposed rule and related analysis.

Analysis and supporting documents used to determine effect on small business or in preparation of economic impact analysis:

This proposed rule will be posted on the Department's website for 14 days to solicit comments from small business.

Fiscal Estimate and Economic Impact Analysis:

The Fiscal Estimate and Economic Impact Analysis are attached.

Effect on small business:

These proposed rules do not have an economic impact on small businesses, as defined in s. 227.114 (1), Stats. The Department's Regulatory Review Coordinator may be contacted by email at Jeffrey.Weigand@wisconsin.gov, or by calling (608) 267-9794

Agency contact person:

Shawn Leatherwood, Rule Coordinator, Department of Safety and Professional Services, 1400 East Washington Avenue, Room 151, P.O. Box 8935, Madison, Wisconsin 53708; telephone 608-261-4438; email at Shancethea.L Leatherwood@wisconsin.gov.

Place where comments are to be submitted and deadline for submission:

Comments may be submitted to Shawn Leatherwood, Rules Coordinator, Department of Safety and Professional Services, Division of Board Services, 1400 East Washington Avenue, Room 151, P.O. Box 8935, Madison, WI 53708-8935, or by email to Shancethea.L Leatherwood@wisconsin.gov. Comments must be received on or before December 18, 2012 to be included in the record of rule-making proceedings.

TEXT OF RULE

SECTION 1. MTBT 1.01 is amended to read:

MTBT 1.01 Authority and intent. The rules in chs. MTBT 1 to ~~5~~ 7 are adopted by the ~~department~~ board pursuant to s. 227.11 (2), Stats., and ch. 460. Stats., to govern the credentialing of massage therapists and body workers.

SECTION 2. 1.02 is repealed and recreated to read:

MTBT 1.02 Definitions. As used in chs. MTBT 1 to 5, unless the context otherwise requires:

(1) "Accrediting agency" means either of the following:

(a) A regional or national accrediting agency recognized by the U.S. department of education.

(b) A state government agency or territorial government agency located in another state or territory of the United States or another country.

(2) "Adjunctive therapy" means any of the following:

(a) The use of a device that stimulates or enhances manual action.

(b) The application of water, lubricants, or other nonprescription topical agents to the skin.

(c) The application of heat or cold to the skin in the absence of an electromagnetic device.

(3) "Approved training program" means a series of classroom courses, not including continuing education, which is approved by the board having a unified purpose which leads to a diploma or degree or to an occupational or vocational objective meeting the requirements of s. MTBT 3.01.

(4) "Board" means the massage therapy and bodywork therapy affiliated credentialing board.

(5) "Classroom hour" means a period of instruction consisting of not less than 50 minutes.

(6) "Client" means a person who has contracted for or who receives the professional services of a massage therapist, bodywork therapist, student or temporary licensee, whether the massage therapist, bodywork therapist, student or temporary licensee is paid or unpaid for the service, and regardless of where such services occur. If a client is a person under the age of 18, the client's parents or legal guardian are also clients. If a person contracts for multiple sessions of treatment, the person remains a client until the full terms of the contract have been fulfilled.

(7) "Direct, immediate, on-premises supervision" means the supervising massage therapist or bodywork therapist is present in the same building with the person being supervised, with fact-to-face contact as necessary to avoid unacceptable risk of harm.

(8) "Direct, immediate, one-to-one supervision" means one-to-one supervision with face-to-face contact between the person being supervised and the supervisor throughout the client contact with the supervisor assisting the person being supervised as necessary.

(9) "General supervision" means indirect, off-premises supervision, with direct, on premises or direct fact-to-face contact between the supervisor and the person being

supervised as necessary. Between direct contacts, the supervisor is required to maintain indirect, off premises telecommunication contact such that the person being supervised can, within 15 minutes, establish direct telecommunication with the supervisor.

(10) "Health care practitioner" means a health care provider as defined in s. 146.81 (2) Stats.

(11) "Informed consent" means a client's voluntary, knowing and understood agreement to the service to be provided by the massage therapist, bodywork therapist, temporary licensee or student. Informed consent requires, at a minimum, that the licensee has provided information about the risks and benefits of the service to be provided that a reasonable person in the client's position would need before making an informed decision concerning the service.

(a) Informed consent shall be documented in writing

(b) A client may withdraw informed consent verbally or in writing at any time before a service is completed.

(c) Informed consent shall include an understanding that the client may, upon request, have a chaperone present while massage therapy or bodywork therapy services are provided.

(d) No service or part of a service may be provided without the clients informed consent or after informed consent has been withdrawn.

(12) "Insured" means any person to whom or for whose benefit an insurer makes a promise in an insurance policy. The term includes policyholders, subscribers, members and beneficiaries.

(13) "Intimate parts" has the meaning given in s. 939.22 (19), Stats.

(14) "License holder" means a person granted a license under this chapter.

(15) "Manual action" includes holding, positioning, rocking, kneading, compressing, decompressing, gliding or percussion the soft tissue of the human body or applying a passive range of motion to the human body without joint mobilization or manipulation.

(16) "Massage therapist or bodywork therapist" means a person who engages in massage therapy or body work.

(17) "Massage therapy or bodywork" means the science and healing art that uses manual actions and adjunctive therapies to palpate and manipulate the soft tissue of the human body, in order to improve circulation, reduce tension, relieve soft tissue pain, or increase flexibility. Massage therapy or bodywork therapy includes determining whether

manual actions and adjunctive therapies are appropriate. Massage therapy or bodywork therapy does not include making a medical, physical therapy, or chiropractic diagnosis.

(18) "Policy holder" means the person who controls the policy by ownership, payment of premiums or otherwise.

(19) "Sexual contact" has the meaning given in s. 939.22 (34), Stats.

(20) "Sexual intercourse" has the meaning given in s. 948.01 (7) (a), Stats.

(21) "Sexually oriented business" means any for-profit entity that offers or provides any of the following:

(a) sexually explicit conversation

(b) exposure of any person's intimate parts except as necessary for competent massage and body work therapy

(c) direct and indirect contact with any persons intimate parts unless necessary for a legitimate massage and body work therapy

(d) prostitution

(e) materials depiction or describing sexually explicit conduct

(22) "Temporary licensee" means a graduate of a massage therapy or bodywork therapy school or program who has met the requirements for and who has been granted a temporary license to practice massage therapy and bodywork therapy as provided in s. ~~XXX~~

SECTION 3. MTBT 2.01 (title) is amended to read

MTBT 2.01 (title) Application for a ~~certificate~~-license

SECTION 4. MTBT 2.03 (title), (1) (a), and (c) are amended to read

MTBT 2.03 (title) Reciprocal ~~certificate~~-license. (1) An individual applying for a ~~certificate~~-license on the basis of a similar license, registration or ~~certificate~~ license in another state or territory of the United States or another country shall:

(a) Submit an application on a form provided by the ~~department~~ board.

(c) Submit evidence satisfactory to the ~~department~~ board.

SECTION 5. MTBT 2.05 (title) and (intro) are amended to read:

MTBT 2.05 (title) Alternate certification-license. The department Board shall grant a ~~certificate~~ license as a massage therapist or bodyworker to a person who satisfies all of the following:

SECTION 6. MTBT 2.05 (3), (5), and (7) are amended to read:

(3) Submits an application for the ~~certificate~~ license to the department board on a form provided by the department board

(5) Submits evidence satisfactory to the department board that the person has in effect as a policyholder insured, malpractice liability insurance coverage in an amount that is not less than \$1,000,000 per occurrence and \$1, 000,000 for all occurrences in one year.

(7) Submits evidence satisfactory to the department board that, during the 2 year period after March 1, 2003, the person was actively engaged in the practice of massage therapy or bodywork. In this subsection, "actively engaged in the practice of massage therapy or bodywork" means having engaged in at least 1500 hours of the practice of massage therapy or bodywork during the 2 year period after March 1, 2003.

SECTION 7. MTBT 3.01 (1) and (5) (b)

(1) An individual applying for a ~~certificate~~ license as a massage therapist or bodyworker who has not graduated from a school of massage therapy or bodywork approved by the educational approval board shall submit an official transcript or other official documentation showing dates and total hours attended and a description of the curriculum completed establishing that he or she has completed an approved training program.

(5) (b) Business, law and ethics: 50 classroom hours, which may include at least 6 classroom hours in the laws of this state and rules of the department board relating to the practice of massage therapy or bodywork required by s. MTBT 2.01 (3) (b).

SECTION 8. MTBT 4.01 (title) and (intro) are amended to read:

MTBT 4.01 (title) Certificate-License expiration. ~~Certificate~~ License for massage therapists and bodyworkers expire on March 1 of each odd-numbered year.

SECTION 9. MTBT 4.02 (title) (intro) (1), and (3) are amended to read:

MTBT 4.02 (title) Renewal of certificate-license. In order to renew a ~~certificate~~ license on or before the renewal date, the ~~certificate~~ license holder shall submit the following to the department board:

(1) A renewal application on a form provided by the department board.

(3) Evidence satisfactory to the ~~department~~ board that he or she has in effect as a policyholder and insured, malpractice liability insurance coverage in an amount that is not less than \$1,000,000 per occurrence and \$1,000,000 for all occurrences in one year.

SECTION 10. MTBT 4.03, 4.04 (1), (a), (c), (2) (a) and (b) are amended to read:

MTBT 4.03 Failure to renew. A ~~certificate~~ license holder who fails to renew a ~~certificate~~ license by the applicable renewal date shall not use any title or description that implies that he or she is credentialed by the ~~department~~ board as a massage therapist or bodyworker until his or her ~~certificate~~ license is renewed under s. MTBT 4.04.

(1) If applying less than 5 years after the renewal date, submitting to the ~~department~~ board all of the following:

(a) An application for renewal on a form provided by the ~~department~~ board.

(c) Evidence satisfactory to the ~~department~~ board that he or she has in effect as a policyholder and insured, malpractice liability insurance coverage in an amount that is not less than \$1,000,000 per occurrence and \$1,000,000 for all occurrences in one year.

(2) (a) Successful completion of educational course work required by the ~~department~~ board to ensure protection of the public health, safety and welfare.

(b) Successful completion of an examination required by the ~~department~~ board to ensure protection of the public health, safety and welfare.

SECTION 11. MTBT 5.01 (9), (16), (17), (18), (20), (27), (28), and (32) are amended to read:

(9) Failing to keep confidential any information that a client gives in confidence to the ~~certificate~~ license holder and any other information that the ~~certificate~~ license holder obtains about a client in the course of practicing massage therapy or bodywork that a reasonable person in the client's position would want kept confidential, unless the information is otherwise required by law to be disclosed or the client specifically authorizes the disclosure of the information.

(16) After a request by the ~~department~~ board, failing to cooperate in a timely manner with the department's investigation of complaints filed against the ~~certificate~~ license holder. There is a rebuttable presumption that a ~~certificate~~ license holder who takes longer than 30 calendar days to respond to a request of the ~~department~~ board has not acted in a timely manner under this subsection.

(17) Violating any rule adopted by the ~~department~~ board relating to the practice of massage therapy or bodywork.

(18) Violating any term, provision or condition of any order issued by the ~~department~~ board.

(19) Failing to practice massage therapy or bodywork within the scope of the ~~certificate~~ license holder's competence, education, training and experience.

(20) Aiding or abetting an ~~uncertified~~ unlicensed person, knowingly conspiring with an ~~uncertified~~ unlicensed person, or allowing one's ~~certificate~~ license to be used by an ~~uncertified~~ unlicensed person to evade the use of title restrictions under s. 460.02, Stats., relating to the practice of massage therapy or bodywork.

(27) Failing to submit a written report to the ~~department~~ board if the ~~certificate~~ license holder is convicted of a felony or misdemeanor, or is found to have committed a violation, in this state or elsewhere, if the circumstances of the felony, misdemeanor or violation substantially relate to the practice of massage therapy or bodywork. The report shall be made on a complaint form provided by the ~~department~~ board and shall be submitted within 30 days after the entry of the judgment of conviction or the judgment that the ~~certificate~~ license holder committed the violation, and shall identify the date, place, and nature of the conviction or finding. If the report is submitted by mail, the report is considered to be submitted on the date that it is mailed. In this subsection, "violation" means a violation of any state or local law that is punishable by a forfeiture.

(28) Failing to display his or her ~~certificate~~ license in his or her place of business or practice so that it can easily be seen and read by the public.

(32) Advertising by a ~~certificate~~ license holder that he or she practices massage therapy or bodywork unless the advertisement includes his or her ~~certificate~~ license number and a statement that the ~~certificate~~ license holder is a ~~certified~~ "licensed massage therapist or bodyworker" or "~~certified~~ licensed massage therapist" or "~~certified~~ licensed bodyworker." A telephone directory listing for which no additional advertising charge is made is not considered advertising.

SECTION 12. MTBT 5.02 (1), (2) (b), (c), (3), and (4) are amended to read:

(1) A ~~certificate~~ license holder shall submit a report to the ~~department~~ board if he or she has reasonable cause to believe that another ~~certificate~~ license holder has committed a crime relating to prostitution under ss. 944.30 to 944.34, Stats., or has had sexual contact or sexual intercourse with a client. If the report relates to sexual contact or sexual intercourse with a client, the report may not identify the client unless the client has provided written consent for disclosure of this information.

(2) (b) Being informed by a person that he or she, while a client of another ~~certificate~~ license holder, engaged in nonmarital sexual contact or sexual intercourse with the other ~~certificate~~ license holder.

(2) (c) Being informed by another ~~certificate~~ license holder that he or she has engaged in nonmarital sexual contact or sexual intercourse with a client, or has done an act prohibited by ss. 944.30 to 944.34, Stats.

(3) The report shall be made on a complaint form provided by the ~~department~~ board. The ~~department~~ board may use the report as the basis for an investigation under s. 460.14 (1), Stats.

(4) A complaint as defined in s. SPS 2.03 (2), filed against a ~~certificate~~ license holder pursuant to s. SPS 2.08, based upon the allegation of one or more acts prohibited under ss. 944.30 to 944.34, Stats., constitutes reasonable cause for the department to believe that a ~~certificate~~ license holder has committed a crime and the ~~department~~ board shall report the belief to the district attorney for the county in which the crime, in the opinion of the ~~department~~ board, occurred.

SECTION 13 Chs.. MTBT 6.01 and 6.02 are created to read:

CHAPTER MTBT 6

TEMPORARY LICENSURE

MTBT 6.01 Authority. The rules in ch. MTBT 6 are adopted under the authority of ss.460.08 and 460.04 (2) (f), Stats.

MTBT 6.02 Temporary license prior to licensure. (1) The board may issue a temporary license to practice massage therapy and bodywork therapy to an applicant for licensure who meets the criteria under s. 460.05, Stats., and who has done all of the following:

(a) Submits a completed application for licensure and a completed application for temporary licensure.

(b) Remits the fee specified in s. 440.05 (1), Stats.

(c) Has successfully completed and educational program as defined in s. MTBT 3.01

(d) Has not previously failed an examination required in s. 460.06, Stats., unless the applicant has subsequently passed the failed examination.

(e) Has passed the state board statutes and rules examination.

(2) Practice during the period of temporary license shall be under the supervision of a licensed massage therapist or bodywork therapist, at the level of general supervision or as necessary to avoid unacceptable risk of harm to the client. The supervising massage therapist or body work therapist is responsible for determining the level of supervision necessary to avoid unacceptable risk of harm to the client.

(a) A person holding a temporary license shall meet face-to-face with the supervising massage therapist or bodywork therapist as necessary to insure that the temporary licensee performs competently, including creation and maintenance of records as required in s. MTBT 5.01 (8).

(b) The temporary licensee shall provide each client the name, contact information and license number for the supervising massage therapist or bodywork therapist responsible for supervision of the temporary licensee.

(c) Prior to commencing any health care service, a temporary licensee shall obtain written informed consent of all clients. The informed consent documentation shall include, in addition to other requirements, an acknowledgement that the temporary licensee is not fully credentialed and that the client has been provided the information required by (b).

(3) A temporary license expires 6 months after the date of issuance or when the Department provides notice that the temporary licensee has failed or passed the examination required by s. 460.06, Stats., whichever is first.

(a) A temporary license shall not be renewed.

(b) No person shall be issued more than one temporary license in any 365 day period.

(4) For purposes of the Board's disciplinary authority the supervising massage therapist or bodywork therapist is responsible for the acts of the temporary licensee under supervision. The Board may discipline the supervising massage therapist or bodywork therapist, student and/or the temporary licensee for any act(s) or omission of the temporary licensee in violation of any state or federal statute, rule, regulation or order of the massage therapy and bodywork therapy affiliated credentialing board or of the medical examining board.

(5) Temporary licensees shall use the title massage therapy temporary licensee or bodywork therapy temporary licensee.

SECTION 14. Chs.. MTBT 7.01 to 7.03 are created to read:

Chapter MTBT 7.01

CONTINUING EDUCATION

MTBT 7.01 Authority. The rules in ch. MTBT 7 are adopted under the authority of s. 460.10, Stats.

MTBT 7.02 Continuing education required. (1) Each licensee is required to complete 24 hours of continuing education prior to renewal of a license to practice as a massage therapist or body work therapist.

(2) Acceptable continuing education must address topics within the scope of practice of massage therapy and body work therapy or related business practices. The topic of at least two of the total continuing education hours in each biennium shall be ethics.

(3) Each licensee shall, at the time of making application for renewal, sign a statement on the application for renewal certifying that the licensee has completed 24 hours of acceptable continuing education, including 2 credits pertaining to ethics, within the 2 calendar years immediately preceding the calendar year for which application for renewal is made.

(4) A licensee may apply to the board for waiver of the requirements of this chapter on grounds of prolonged illness or disability or other similar circumstances. The Board will consider each request individually on its merits.

(5) One hour of continuing education is awarded for each 50 minutes of instruction or its equivalent.

(6) Each licensee shall maintain verifiable evidence of completion of the continuing education activity until the licensee submits the next subsequent application for renewal of a license to practice massage therapy or body work therapy.

MTBT 7.03 Acceptable continuing education activities. The board shall accept the following in satisfaction of the biennial training requirement provided under s. MTBT 7.02.

(1) Continuing education activities approved or provided by:

(a) Massage therapy or body work therapy schools or training programs approved pursuant to s. 460.095, Stats.

(b) Institutions of higher education as s. 106.57 (1) (c), Stats.

(c) Local, state or national chapters of professional organizations that address improvement of the profession, including the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM), National Certification

Board for Therapeutic Massage and Bodywork (NCBTMB), and the Federation of State Massage Therapy Boards (FSMTB).

(2) Continuing education activities may be in the form of in-person instruction, distance learning, online activities, audiovisual recordings, audio recordings and professional literature review.

(END OF TEXT OF RULE)

The rules adopted in this order shall take effect on the first day of the month following publication in the Wisconsin administrative register, pursuant to s. 227.22 (2) (intro.), Stats.

Dated _____

Agency _____

Chairperson
Massage Therapy and Bodywork Therapy
Affiliated Credential Board

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Sandy Nowack Legal Counsel		2) Date When Request Submitted: September 5, 2012 Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: September 19, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? MED10, Discussion and Vote, Informed Consent	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: The Board will continue its previous discussion on informed consent within the code of unprofessional conduct and will vote on proposed language for the MED10 revision. Based on the Board's previous direction, none of these motions provide a definition of "informed consent". Based on the Board's previous direction, possible motions include but are not limited to: Move subject to technical legal revisions and review prior to public hearing, to accept draft rule language concerning informed consent as follows: 1. Any violation of Wis. Stat. sec 448.30. (Note that sec. 448.30 does not specifically require documentation of informed consent in any fashion, does not specifically require that consent be obtained, and does not specifically prohibit provision of service after consent has been withdrawn.) 2)) Performing any act constituting the practice of medicine and surgery without the patient's informed consent, or after informed consent has been withdrawn, whether orally or in writing. 3) Subject to Wis. Stat. sec 448.30, performing any act constituting the practice of medicine and surgery on any patient without the patient's informed consent or after the patient has withdrawn informed consent, whether verbally or in writing, or any of the following: a. Failure to document informed consent; or b. Failure to inform the patient that any medical act may or will be performed by a non-physician delegate. NOTE that 3.b is misconduct under current law as "aiding and abetting the unlicensed practice of medicine."			

11)

Authorization

London P. Runk

12/5/12

Signature of person making this request

Date

Supervisor (if required)

Date

Bureau Director signature (indicates approval to add post agenda deadline item to agenda) Date

Directions for including supporting documents:

1. This form should be attached to any documents submitted to the agenda.
2. Post Agenda Deadline items must be authorized by a Supervisor and the Board Services Bureau Director.
3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.

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

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7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: The Board will continue its previous discussion on self reports of practice limitations within the code of unprofessional conduct and will vote on proposed language for the MED10 revision. Based on the Board's previous direction, possible motions include: Move, subject to technical legal revisions and review prior to public hearing, to accept draft rule language concerning self report of practice limitations, as set out in the agenda document as option 1, 2, or 3. NOTE: Counsel understood that the Board has determined that it will not require self-reporting of practice limitations that occur as a result of peer review, due to pending legislative proposals.			
11) Authorization <div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center;"> Signature of person making this request </div> <div style="text-align: center;"> 9/5/12 Date </div> </div>			
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda) Date			
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Counsel understands Board instruction to include only motions that do NOT require disclosure of loss of privilege due to peer review.

- 1. Option that would require reporting only of adverse actions by other credentialing authorities, similar to current law, but specifying a time by which the report must be made.**

Failure, within thirty days, to report to the Department a final adverse action taken against the licensee's authority to practice medicine and surgery by another licensing or credentialing jurisdiction concerned with the practice of medicine and surgery.

NOTE: This option would omit the requirement of self-reporting based on loss of privilege by authority of any governmental entity except a credentialing agency, e.g., the DEA.

- 2. Modified without reference to peer review or health care organization, but requiring self-report of loss or limitation of authority to practice by any government entity, including DEA registration.**

Failure, within thirty days, to report to the Department adverse action, whether final or temporary, taken against the licensee's authority to practice medicine and surgery as follows:

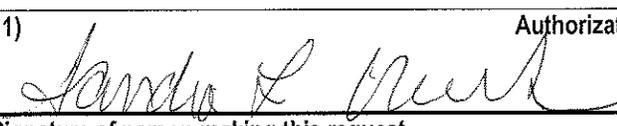
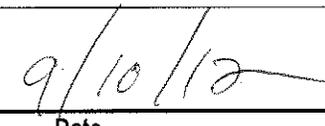
- a. Any adverse action by another licensing or credentialing jurisdiction concerned with the practice of medicine and surgery; or
- b. Any adverse action by any division of the state or federal government that results in limitation or loss of authority to perform any act constituting the practice of medicine and surgery, including but not limited to authorization to prescribe controlled substances.

**Note removal of reference to "health care organization" was removed by legal counsel as overly broad.*

See informational item on Wisconsin law pertaining to peer review. Note that if provisions of mandated reporting are complied with, the Department would get a report through mandated reporting more expediently than it would in waiting for thirty days after the effective date of any suspension or revocation after peer review. Note too that there are conditions to the Board's actions in response to hospital report that create additional Board requirements when a hospital makes a report pursuant to Wis. Stat. § 50.36/

**State of Wisconsin
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3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: September 19, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? MED10, Discussion and Vote, Legislation to amend sec 50.36(3)	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: The Board will continue its previous discussion pertaining to hospital reports of practice limitations pursuant to Wis. Stat. sec 50.26(3), and if the Board so decides, may consider the following motion: Move that the Wisconsin Medical Examining Board work collaboratively with the Wisconsin Hospital Association or the Wisconsin Medical Society or both to consider amendments to Wis. Stat. sec 50.36(3) that would provide notice of a practice limitation to the MEB at the same time the report is made to the National Practitioner's Data Bank, or other mutually agreeable proposal to insure timely reports to the MEB under this section.			
11) Authorization <div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center;">  Signature of person making this request </div> <div style="text-align: center;">  Date </div> </div> <hr/> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;">Supervisor (if required)</div> <div style="width: 20%;">Date</div> </div> <hr/> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;">Bureau Director signature (indicates approval to add post agenda deadline item to agenda)</div> <div style="width: 20%;">Date</div> </div>			
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7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: The Board will continue its previous discussion on related law violations within the code of unprofessional conduct and will vote on proposed language for the MED10 revision. Based on the Board's previous direction, possible motions include: Move, subject to technical legal revisions and review prior to public hearing, to accept draft rule language concerning informed consent as set out in the agenda document as option 1, 2, or 3.			
11) Authorization <div style="display: flex; justify-content: space-between; align-items: center;"> <div style="border-bottom: 1px solid black; width: 45%; text-align: center;">  </div> <div style="border-bottom: 1px solid black; width: 45%; text-align: center;"> 9/5/12 </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> Signature of person making this request Date </div> <hr/> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> Supervisor (if required) Date </div> <hr/> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> Bureau Director signature (indicates approval to add post agenda deadline item to agenda) Date </div>			
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1. Work group recommendation, without reference to crimes involving persistent use of alcohol.

“Any federal or state law or rule that is substantially related to the practice of medicine and surgery” includes, but is not limited to, conduct constituting a violation of the rules of this board or any other credentialing agency, and or a misdemeanor or felony crime, within this state or without, the circumstances of which involve aiding, abetting, actual or attempted dishonesty.”

Violation or conviction of any federal or state law, including criminal law, that bars the following conduct and which is therefore substantially related to the practice of medicine and surgery:

- a. Theft or fraud;
- b. Violence;
- c. Sexual contact with a patient, patient’s guardian or family member, or any act performed in the presence of a patient, patient’s guardian or family member, for the purposes of sexual gratification;
- d. Victimization of children or individuals at risk as defined at Wis. Stat. § 940.285;
- e. Any crime occurring in the course of the practice of medicine and surgery or in a facility in which medicine or surgery is practiced;
- f. Administering, dispensing, prescribing, supplying, ordering, obtaining or using controlled substances as defined in s. 961.01 (4), Stats., otherwise than in the course of legitimate professional practice, or as otherwise prohibited by law;

A certified copy of any document demonstrating the entry of a guilty, nolo contendere plea or deferred adjudication (with or without expungement) of a crime substantially related to the practice of medicine shall be conclusive evidence of a violation of this subsection.

Except as provided in sub. XX), violation or conviction of any federal or state law or rule that is substantially related to the practice of medicine and surgery.

- a. Except as otherwise provided by law, a certified copy of a relevant decision by a state or federal court or agency charged with making legal determinations relevant to this subsection is conclusive evidence of findings of facts and conclusions of law contained therein.
- b. Under this subsection, the division of enforcement has the burden of proving that the act is substantially related to the practice of medicine and surgery.

2. Option that does not specify particular crimes and would therefore require the Division to prove that any crime is substantially related to the practice of medicine and surgery.

Violations or convictions of any federal or state law, including criminal law, that is substantially related to the practice of medicine and surgery.

3. Violations or convictions of offenses affecting caregiver eligibility for Chapter 50 programs (see attached).

Option that identifies some particular crimes but not those related to drug offenses or dishonesty. Because particular crimes would be designated by statutory reference, if the Board wished to depart from that particular list of crimes, the Division would be required to prove equivalence and/or substantial relationship. Designated statutory references would not include crimes that constituted the same acts unless proven to be substantially related to the practice of medicine. On the other hand, designated statutory references, while more narrow in scope, would clearly identify those particular crimes as under the Board's scrutiny.

See attached list of citations proposed as the delineated crimes.

940.01	First degree intentional homicide
940.02	First degree reckless homicide
940.03	Felony murder
940.05	Second degree intentional homicide
940.12	Assisting suicide
940.19 (2), (3), (4), (5) or (6)	Battery; substantial battery aggravated battery
940.22 (2) or (3)	Sexual exploitation by therapist; duty to report
940.225 (1), (2) or (3)	Sexual assault (first second or third degree)
940.285 92)	Abuse of individuals at risk
940.29	Abuse of residents of penal facilities
940.295	Abuse and neglect of patients and residents
948.02 (1) or (2)	Sexual assault of a child (first and second degree)
948.03 (2) (a), (b) or (c)	Physical abuse of a child (intentional causation of bodily harm)
948.05	Sexual exploitation of a child
948.051	Trafficking of a child
948.055	Causing a child to view or listen to sexual activity
948.06	Incest with a child
948.07	Child enticement
948.08	Soliciting a child for prostitution
948.085	Sexual assault of a child placed in substitute care
948.11 (2)(a) or (am)	Exposing a child to harmful material or harmful descriptions or narrations
948.12	Possession of child pornography
948.13	Child sex offender working with children
948.21 (1)	Neglecting a child
948.30	Abduction of another's child, constructive custody
948.53	Child unattended in child care vehicle
	Violation of the law of any other state or U.S. jurisdiction that would be violation of any of the above.

940.19 (1)	Misdemeanor battery
940.195	Battery to an unborn
940.20	Battery, special circumstances
940.30	Reckless endangerment
942.08	Invasion of privacy
947.01	Disorderly conduct
947.013	Harassment

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

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3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: September 19, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? MED10, Discussiou and Vote, Business Practices	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: The Board will continue its previous discussiou on business practices within the code of unprofessional conduct and will vote on proposed language for the MED10 revision. Based on the Board's previous direction, possible motions include: Move, subject to techuical legal revisions aud review prior to public heariug, to accept draft rule language concerning business practices as set out in the agenda document as option 1 or 2.			
11) Authorization <div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center;">  _____ Signature of person making this request </div> <div style="text-align: center;"> 9/5/12 _____ Date </div> </div>			
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
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1 **1. Work group recommendation with amendments:**

2
3 Illegal or unethical business practices, including but not limited to:

- 4
5 a. Fraud, deceit or misrepresentation in obtaining or attempting to obtain any fee or third-
6 party reimbursement;
7 b. Engaging in uninvited, in-person solicitation of actual or potential patients who, because
8 of their particular circumstances, are vulnerable to undue influence;
9 c. Any violation of Wis. Stat. § 448.08.

10 *NOTE: see text of § 448.08 below.*

11 **Because the concern about board certification is not limited to advertisement or billing**
12 **practices, work group recommended board certification as a distinct rule:**

13 Representing, claiming or causing the appearance that the physician possesses medical specialty
14 certification by a certifying organization under any of the following circumstances:

- 15 a. The specialty in which certification exists is not identified;
16 b. The identity of the certifying organization, if other than ABMS or AOA, is not disclosed;
17 c. Certification does not exist or is not current.

18
19 **2. Multiple distinct rules based on a version of FSMB model language as follows:**

20
21 Obtaining any fee by fraud, deceit or misrepresentation.

22 Employing unethical or illegal billing practices.*

23 Directly or indirectly giving or receiving any fee, commission, rebate or other compensation for
24 professional services not actually and personally rendered [unless allowed by law], though this
25 prohibition should not preclude the legal functioning of lawful professional partnerships,
26 corporations or associations.

27 Representing, claiming or causing the appearance that the physician possesses a particular
28 medical specialty certification by a Board recognized certifying organization (ABMS, AOA) if
29 not true.

30 **Does the Board intend to limit disciplinary actions to the delineated conduct (rather*
31 *than “includes but is not limited to”)?*

32 **Note that stakeholders proposed the term “abusive” and not “unethical”. However, for*
33 *reasons discussed during the August meeting, board legal counsel cannot recommend use*
34 *of the term “abusive” as vague and fraught with difficulties in enforcement.*

35 **Note that the WMS and WHA recommendation included addition of the phrase "unless*
36 *allowed by law". Legal counsel opines that this phrase is either legally extraneous or, if*
37 *not intended to be extraneous, could give physicians latitude to engage in business*
38 *practices the Board does not anticipate as previously permitted for other businesses but*
39 *not for physicians.*

40
41 **448.08 Fee splitting; separate billing required, partnerships and corporations;**
42 **contract exceptions.**

43 **(1) DEFINITIONS.** As used in this section:

44 **(a) "Hospital"** means an institution providing 24-hour continuous service to patients confined
45 therein which is primarily engaged in providing facilities for diagnostic and therapeutic services
46 for the surgical and medical diagnosis, treatment and care, of injured or sick persons, by or under
47 the supervision of a professional staff of physicians and surgeons, and which is not primarily a
48 place of rest for the aged, drug addicts or alcoholics, or a nursing home. Such hospitals may
49 charge patients directly for the services of their employee nurses, nonphysician anesthetists,
50 physical therapists and medical assistants other than physicians or dentists, and may engage on a
51 salary basis interns and residents who are participating in an accredited training program under
52 the supervision of the medical staff, and persons with a temporary educational certificate issued
53 under s. 448.04 (1) (c).

54 **(b) "Medical education and research organization"** means a medical education and medical
55 research organization operating on a nonprofit basis.

56 **(1m) FEE SPLITTING.** Except as otherwise provided in this section, no person licensed or
57 certified under this subchapter may give or receive, directly or indirectly, to or from any person,
58 firm or corporation any fee, commission, rebate or other form of compensation or anything of
59 value for sending, referring or otherwise inducing a person to communicate with a licensee in a
60 professional capacity, or for any professional services not actually rendered personally or at his or
61 her direction.

62 **(2) SEPARATE BILLING REQUIRED.** Any person licensed under this subchapter who renders
63 any medical or surgical service or assistance whatever, or gives any medical, surgical or any
64 similar advice or assistance whatever to any patient, physician or corporation, or to any other
65 institution or organization of any kind, including a hospital, for which a charge is made to such
66 patient receiving such service, advice or assistance, shall, except as authorized by Title 18 or Title
67 19 of the federal social security act, render an individual statement or account of the charges
68 therefor directly to such patient, distinct and separate from any statement or account by any
69 physician or other person, who has rendered or who may render any medical, surgical or any
70 similar service whatever, or who has given or may give any medical, surgical or similar advice or
71 assistance to such patient, physician, corporation, or to any other institution or organization of
72 any kind, including a hospital.

73 **(3) BILLING FOR TESTS PERFORMED BY THE STATE LABORATORY OF HYGIENE.** A person
74 other than a state or local government agency who charges a patient, other person or 3rd-party
75 payer for services performed by the state laboratory of hygiene shall identify the actual amount
76 charged by the state laboratory of hygiene and shall restrict charges for those services to that
77 amount.

78 **(4) PROFESSIONAL PARTNERSHIPS AND CORPORATIONS PERMITTED.** Notwithstanding any
79 other provision in this section, it is lawful for 2 or more physicians, who have entered into a bona
80 fide partnership for the practice of medicine, to render a single bill for such services in the name
81 of such partnership, and it also is lawful for a service corporation to render a single bill for
82 services in the name of the corporation, provided that each individual licensed, registered or

83 certified under this chapter or ch. 446, 449, 450, 455, 457 or 459 that renders billed services is
84 individually identified as having rendered such services.

85 **(5) CONTRACT EXCEPTIONS; TERMS.** Notwithstanding any other provision in this section,
86 when a hospital and its medical staff or a medical education and research organization and its
87 medical staff consider that it is in the public interest, a physician may contract with the hospital or
88 organization as an employee or to provide consultation services for attending physicians as
89 provided in this subsection.

90 **(a)** Contracts under this subsection shall:

91 **1.** Require the physician to be a member of or acceptable to and subject to the approval of
92 the medical staff of the hospital or medical education and research organization.

93 **2.** Permit the physician to exercise professional judgment without supervision or
94 interference by the hospital or medical education and research organization.

95 **3.** Establish the remuneration of the physician.

96 **(b)** If agreeable to the contracting parties, the hospital or medical education and research
97 organization may charge the patient for services rendered by the physician, but the statement to
98 the patient shall indicate that the services of the physician, who shall be designated by name, are
99 included in the departmental charges.

100 **(c)** No hospital or medical education and research organization may limit staff membership to
101 physicians employed under this subsection.

102 **(d)** The responsibility of physician to patient, particularly with respect to professional
103 liability, shall not be altered by any employment contract under this subsection.

104

105

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Department of Safety & Professional Services**

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<table style="width: 100%; border: none;"> <tr> <td style="width: 10%; border: none;">11)</td> <td style="width: 50%; border: none; text-align: center;">Authorization</td> <td style="width: 40%; border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none; text-align: center;"></td> <td style="border: none; text-align: center;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none; text-align: center;">Signature of person making this request</td> <td style="border: none; text-align: center;">Date</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none; text-align: center;">Supervisor (if required)</td> <td style="border: none; text-align: center;">Date</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none; text-align: center;">Bureau Director signature (indicates approval to add post agenda deadline item to agenda)</td> <td style="border: none; text-align: center;">Date</td> </tr> </table>				11)	Authorization						Signature of person making this request	Date		Supervisor (if required)	Date		Bureau Director signature (indicates approval to add post agenda deadline item to agenda)	Date
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1
2
3 **OTHER PROVISIONS**

4 **Move subject to technical legal revision and review prior to public hearing, to**
5 **accept/reject/amend draft language of proposed definition “xx”; and/or**

6 **Move subject to technical legal revision and review prior to public hearing to**
7 **accept/reject/amend draft language, other provisions, lines xx-xx.**

8 Statement of Intent

9 Physicians act with a high level of independence and responsibility, often in emergencies. Every
10 physician represents the medical profession in the community and must do so in a manner worthy
11 of the trust bestowed upon the physician and the profession. The competent practice of medicine
12 and surgery requires that care of the patient is paramount. Physicians must therefore act with
13 honesty, respect for the law, reasonable judgment, competence and respect for patient boundaries.

14
15 “Direct, immediate, one-to-one supervision” means one-to-one supervision with face-to-face
16 contact between the person being supervised and the supervisor throughout the patient contact,
17 with the supervisor assisting the person being supervised as necessary.

18
19 “General supervision” means indirect, off-premises supervision, with direct, on-premises or direct
20 face-to-face contact between the supervisor and the person being supervised, as necessary.
21 Between direct contacts, the supervisor is required to maintain indirect, off-premises
22 telecommunication contact such that the person being supervised can, within 15 minutes, establish
23 direct telecommunication with the supervisor.

24
25 “Intimate parts” has the meaning set forth in Wis. Stat. § 939.22(19).¹

26
27 “Negligence in the practice of medicine” means an act performed without the care and skill of
28 reasonable physicians who perform the act in question, whether or not the negligent care results in
29 actual harm to the patient. (NOTE: WHA prefers the term not be defined).

30
31 “Patient health care records” has the meaning set forth in Wis. Stat. § 146.82(4), and shall also
32 include records of prescription medications administered, dispensed or prescribed for a patient.²

33
34 “Sexual contact” has the meaning set forth in Wis. Stat. § 948.01(5).³

¹ Breast, buttock, anus, groin, scrotum, penis, vagina or pubic mound of a human being.

² All records related to the health of a patient prepared by or under the supervision of a health care provider; and all records made by an ambulance service provider...includes billing statements and invoices for treatment or services provided by a health care provider and includes health summary forms prepared under § 302.388(2). [does not include pseudoephedrine sales records from pharmacy, fetal monitor tracings or a pupil’s physical health records maintained by a school]

³ (5) "Sexual contact" means any of the following: (a) Any of the following types of intentional touching, whether direct or through clothing, if that intentional touching is either for the purpose of sexually degrading or sexually humiliating the complainant or sexually arousing or gratifying the defendant: 1. Intentional touching by the defendant or, upon the defendant's instruction, by another person, by the use of any body part or object, of the complainant's intimate parts. 2. Intentional touching by the complainant, by the use of any body part or object, of the defendant's intimate parts or, if done upon the defendant's instructions, the intimate parts of another person.

35
36 “Sexually explicit conduct” has the meaning set forth in Wis. Stat. § 948.01(7)⁴
37
38 Having any credential pertaining to the practice of medicine and surgery or any act constituting
39 the practice of medicine and surgery become subject to adverse action by any agency of this or
40 another state, or by any agency or authority within the federal government, which results in
41 limitation, restriction, suspension, revocation or any disciplinary action.
42
43 a. This subsection applies to licenses, permits, registrations or any other privileges that
44 pertain to the practice of medicine and surgery, including registration by federal drug
45 enforcement agencies;
46 b. This subsection applies whether the adverse action results in temporary or permanent
47 limitation, restriction, suspension, revocation or disciplinary action;
48 c. This subsection applies whether or not the adverse action is accompanied by findings of
49 negligence or unprofessional conduct.
50
51 Knowingly, recklessly or negligently divulging a privileged communication or other confidential
52 patient health care information except as required or permitted by state or federal law.
53
54 Negligence in the practice of medicine.
55 a. A certified copy of any document demonstrating that a court or a panel established under §
56 655.02, Stats., has found the physician negligent in the course of practicing medicine and
57 surgery shall be conclusive evidence of a violation of this subsection.
58 b. A certified copy of a relevant decision by a state or federal agency charged with making
59 relevant legal determinations is conclusive evidence of findings of facts and conclusions of
60 law contained therein.
61
62 Departure from or failure to conform to the standard of minimally competent medical practice,
63 which creates unacceptable risk of harm to the patient or the public, whether or not the act or
64 omission resulted in actual harm to any person.
65

(b) Intentional penile ejaculation of ejaculate or intentional emission of urine or feces by the defendant or, upon the defendant's instruction, by another person upon any part of the body clothed or unclothed of the complainant if That ejaculation or emission is either for the purpose of sexually degrading or sexually humiliating the complainant or for the purpose of sexually arousing or gratifying the defendant.

⁴ (7) "Sexually explicit conduct" means actual or simulated: (a) Sexual intercourse, meaning vulvar penetration as well as cunnilingus, fellatio or anal intercourse between persons or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal opening either by a person or upon the person's instruction. The emission of semen is not required; (b) Bestiality; (c) Masturbation; (d) Sexual sadism or sexual masochistic abuse including, but not limited to, flagellation, torture or bondage; or (e) Lewd exhibition of intimate parts.

66 Engaging in sexually explicit conduct, sexual contact, exposure, gratification or other sexual
67 behavior with or in the presence of a patient, a patient's immediate family member or a person
68 responsible for the patient's welfare.

- 69
- 70 a. Sexual motivation may be determined from the totality of the circumstances and is
71 presumed when the physician has contact with a patient's intimate parts without legitimate
72 medical justification for doing so.
 - 73 b. For the purposes of this subsection, an adult receiving treatment shall continue to be a
74 patient for two years after the termination of professional services.
 - 75 c. If the person receiving treatment is a minor, the person shall continue to be a patient for the
76 purposes of this subsection for two years after termination of services or for two years after
77 the patient reaches the age of majority, whichever is longer.
 - 78 d. It is a violation of this section for a physician to engage in any sexual contact or conduct
79 with or in the presence of a patient or former patient who lacks the ability to consent for
80 any reason, including but not limited to medication or psychological or cognitive
81 disability.

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OTHER PROVISIONS
WITH SUGGESTED CHANGES NOT ADOPTED BY WORK GROUP

“Adequate supervision” means supervision by a physician whose license is in good standing and requires that: the supervising physician has knowledge of the subordinate’s training, skill and experience pertaining to the acts undertaken; the supervising physician is competent and credentialed to perform the act; and there is adequate physician-to-subordinate ratio, taking into consideration the training, skill and experience of the subordinate(s), risk of harm to the patient due to the nature of the procedure, and risk of harm due to characteristics of the patient. *Work group adopted recommendation to omit “the supervising physician knows in advance which acts will be undertaken”. Work group declined recommendation to modify “characteristics” in the last sentence to say “known” characteristics.*

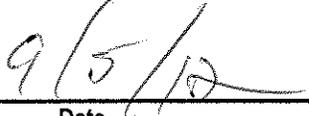
“Direct, on-premises supervision” means the supervising physician is physically present in the same building with the person being supervised, with face-to-face contact as necessary. *Work group declined recommendation to refer to the same “facility” as opposed to “building”.*

Engaging in fraud or misrepresentation in applying for or procuring a medical license, in connection with applying for or procuring periodic renewal of a medical license, or in otherwise maintaining licensure. *Work group declined to accept proposal to delete “engaging in”.*

Engaging in repeated or significant disruptive behavior or interaction with physicians, hospital personnel, patients, family members or others, that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered. *Work group declined to adopt suggestion to add the words “Found to be” at the beginning of the paragraph.*

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7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: The Board will discuss social media within the code of unprofessional conduct in anticipation of a vote during the October meeting. Will require drafting request to legal counsel.			
11) Authorization <div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center;">  Signature of person making this request </div> <div style="text-align: center;">  Date </div> </div> <hr/> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;">Supervisor (if required)</div> <div style="width: 20%;">Date</div> </div> <hr/> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;">Bureau Director signature (indicates approval to add post agenda deadline item to agenda)</div> <div style="width: 20%;">Date</div> </div>			
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“Social media” means electronic communication through which users create online communities to share information, ideas, personal messages, photographs, recordings or any combination thereof.

“Social networking” means networking using an online service, platform, or site that focuses on building social relations among people who share interests or activities or both.

General rule:

Use of the internet, computer technology, or other electronic media to facilitate or commit any act or part of any act that constitutes unprofessional conduct as defined in this section.

Specific rules:

Communicating with a patient through any social media, including but not limited to any personal social networking site, whether or not the patient consents to such communication.

Disclosing confidential patient health care information on any internet site, including but not limited to professional social networks, under any of the following circumstances:

- a) Without the patient’s authorization for disclosure of confidential patient health care information;
- b) For purposes other than the legitimate practice of medicine and surgery; or
- c) The site does not maintain confidentiality or prohibit re-disclosure of patient health care information.

Rule concerning conduct that calls into question fitness to practice medicine:

Communicating through any social media, in any manner that depicts or describes states of impairment due to drugs or alcohol, sexually explicit conduct, or other conduct that presents evidence that the licensee is not fit to meet standards of conduct required of one who practices medicine and surgery.

Model Policy Guidelines for
the Appropriate Use of Social
Media and Social Networking
in Medical Practice

PARTICIPANTS ON THE SPECIAL COMMITTEE ON ETHICS AND PROFESSIONALISM

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Report of the Special Committee on Ethics and Professionalism

Table of Contents

Introduction and Charge	1
Section One	
Preamble	2
Section Two	
An Appropriate Physician-Patient Relationship	4
Section Three	
Parity of Professional and Ethical Standards	6
Section Four	
Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice	7
Section Five	
Key Definitions and Glossary	10
Section Six	
References	12

Introduction and Charge

In recent years the medical profession has become aware of the opportunities and challenges that social media and social networking websites present for physicians. As technology has advanced, many hospitals and health care organizations have found it necessary to create their own policies in order to protect physicians and patients alike. In 2011, FSMB Chair Janelle A. Rhyne, M.D., MACP, asked the members of the Special Committee on Ethics and Professionalism to develop guidelines for state medical and osteopathic boards to consider for their use in educating their licensees on the proper use of social media and social networking websites.

The Special Committee on Ethics and Professionalism was charged with providing ethical and professional guidance to the FSMB membership with regard to the use of electronic and digital media by physicians (and physician assistants, where appropriate) that may be used to facilitate patient care and nonprofessional interactions. Such electronic and digital media include, but are not limited to, e-mail, texting, blogs and social networks. The Committee's proposed model guidelines contained in this report also focus on ways that physicians can protect the privacy and confidentiality of their patients as well as maintain a standard of professionalism in all social media and social networking interactions.

The FSMB is grateful for the efforts of the members of the Special Committee on Ethics and Professionalism who provided input and direction for this project.

Model Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice

Section One

Preamble

The use of social media has become increasingly important across all industries – including health care. *QuantiaMD* surveyed more than 4,000 physicians and reported in September 2011 that 87 percent use a social media website for personal use and 67 percent use social media for professional purposes.¹ In addition, there is evidence that physicians connect with patients through social media websites. Research indicates that 35 percent of practicing physicians have received friend requests from a patient or a member of their family, and 16 percent of practicing physicians have visited an online profile of a patient or patient's family member.²

Social media use presents several challenging questions for administrators and physicians, such as where the boundary of professionalism lies, and whether work experiences can be shared without violating the privacy and confidentiality of patients. One meta-analysis of physician blogs found that nearly 17 percent included enough information about patients for them to be identified.³

Medical schools and their students often use online social networking websites,^{4,5} and students have been disciplined for posting unprofessional online content.⁶ In addition, most physician licensing authorities in the United States have reported incidents of physicians engaging in online professionalism violations, many of which have resulted in serious disciplinary actions. In a 2010 survey of Executive Directors at state medical boards in the United States, 92 percent indicated that violations of online professionalism were reported in their jurisdiction. These violations included Internet use for inappropriate contact with patients (69 percent), inappropriate prescribing (63 percent), and misrepresentation of credentials or clinical outcomes (60 percent). In response to these violations, 71 percent of boards held formal disciplinary proceedings and 40 percent issued informal warnings. Outcomes from the disciplinary proceedings included serious actions such as license limitation (44 percent), suspension (29 percent), or revocation (21 percent) of licensure.⁷

These growing concerns about physician use of social media underscore the need for social media policies. Many hospitals and health care organizations, such as the American Medical Association, American College of Physicians, Cleveland Clinic, and Mayo Clinic, have developed social media policies.^{8,9,10,11}

Social media has enormous potential for both physicians and their patients. It can be used to disseminate information and forge meaningful professional relationships. However, these benefits must occur within the proper framework of professional ethics, and physicians need information on the importance of maintaining the same professional and ethical standards in their online activity or communications using other forms of electronic media.

The FSMB has developed this policy to encourage physicians who use social media and social networking to protect themselves from unintended consequences of such practices and to maintain the public trust by:

- Protecting the privacy and confidentiality of their patients
- Avoiding requests for online medical advice
- Acting with professionalism
- Being forthcoming about their employment, credentials and conflicts of interest
- Being aware that information they post online may be available to anyone, and could be misconstrued

The FSMB acknowledges that there may be instances in which a physician's professionalism or care is questionable and not addressed in this policy or other FSMB policy. Any time a physician enters into a relationship with a patient, whether it is electronically or in person, the physician should abide by the same rules or statutes established by the state medical board.

Section Two

An Appropriate Physician-Patient Relationship

The health and well-being of a patient depend upon a collaborative effort between the physician and patient. The physician-patient relationship is fundamental to the provision of acceptable medical care, and physicians are expected to recognize the obligations, responsibilities and patient rights associated with establishing and maintaining an appropriate physician-patient relationship. The relationship between a physician and patient begins when an individual seeks assistance from a physician for a health-related matter, and the physician agrees to undertake diagnosis and treatment of the patient.¹² The physician-patient relationship can begin without a personal encounter, which allows for online interactions to constitute the beginning of the relationship. Physicians should remember that when using electronic communications they may be unable to verify that the person on the other end of the electronic medium is truly the patient; likewise, the patient may not be able to verify that a physician is on the other end of the communication. For that reason, the standards of medical care do not change by virtue of the medium in which physicians and their patients choose to interact.

The following narratives demonstrate examples where unintended consequences of physicians' use of social media and social networking may undermine a proper physician-patient relationship and the public trust.

1. A urologist who is an astute clinician and well respected by his colleagues recently began posting his comments, views and observations on Twitter. The same day that the United States Preventive Services Task Force came out with a recommendation, in October 2011, against routine Prostate-Specific Antigen (PSA) screening in healthy men for prostate cancer, he posted a tweet with writing that used disrespectful language to disagree with the recommendation. The tweet has now gone viral and has been read by many of his patients, colleagues, fellow researchers, family and friends.
2. A patient noted disrespectful language on a physician's blog when the physician expressed frustration towards another patient who had to visit the emergency department multiple times for failing to monitor her sugar levels. The physician referred to the patient as "lazy" and "ignorant" on their blog.
3. Approximately two years after a physician left his private practice, a former patient asked to "friend" him on Facebook. The physician had set up a Facebook account to participate in a review course for Maintenance of Certification (MOC), but remained on Facebook to stay in touch with family. The physician felt conflicted about the request because he was no longer the patient's physician, and had no intention of returning to private practice. The patient was also very emotionally fragile, and cried at most office visits. The physician wrestled with whether or not to accept the request, but eventually did so for fear that rejecting the request would damage the former patient's self-esteem. The former patient never posted anything inappropriate, and only contacted the physician to wish him a happy birthday. The physician

still feels uncomfortable maintaining this online “friendship,” and has considered closing his Facebook account.

4. A psychiatrist in her 30s used Facebook to befriend a former female patient of similar age who she took care of when she was a psychiatry resident in another state. They had “hit it off” because they had similar tastes in music and art and developed a level of trust that the patient said she had not had with anyone else. They now periodically exchange pleasantries on Facebook, but lately the patient’s affect online appears different, worrying the psychiatrist. The psychiatrist is planning to spend the holidays with her family in the same state as her former patient, and is considering getting together with her former patient to “catch up,” but is unsure how to properly initiate contact with her former patient. Should the psychiatrist just meet her for coffee? Is it appropriate for them to meet at all? She knows she probably shouldn’t use Facebook because it may not be private, but she also doesn’t want to give the patient her personal e-mail address.
5. A concerned patient notes that her physician frequently describes “partying” on his Facebook page, which is accompanied by images of himself intoxicated. The patient begins to question whether her physician is sober and prepared to treat her when she has early morning doctor’s appointments.
6. A physician comes across the profile of one of his patients on an online dating website and invites her to go on a date with him. The patient feels pressured to accept the invitation because her next appointment with her physician would be awkward if she refuses.
7. A first-year resident films another doctor inserting a chest tube into a patient. The patient’s face is clearly visible. The resident posts the film on YouTube for other first-year residents to see how to properly do the procedure.

These examples highlight the importance of proper boundaries within the physician-patient relationship. Even seemingly innocuous online interactions with patients and former patients may violate the boundaries of a proper physician-patient relationship.

Physicians should not use their professional position, whether online or in person, to develop personal relationships with patients. The appearance of unprofessionalism may lead patients to question a physician’s competency. Physicians should refrain from portraying any unprofessional depictions of themselves on social media and social networking websites.

Section Three

Parity of Professional and Ethical Standards

To ensure a proper physician-patient relationship, there should be parity of ethical and professional standards applied to all aspects of a physician's practice, including online interactions through social media and social networking sites. Referencing the FSMB House of Delegate's *Model Guidelines for the Appropriate Use of the Internet in Medical Practice*, adopted in 2002, physicians using social media and social networking sites are expected to observe the following ethical standards:

Candor

Physicians have an obligation to disclose clearly any information (e.g., financial, professional or personal) that could influence patients' understanding or use of the information, products or services offered on any website offering health care services or information.

Privacy

Physicians have an obligation to prevent unauthorized access to, or use of, patient and personal data and to assure that "de-identified" data cannot be linked back to the user or patient.

Integrity

Information contained on websites should be truthful and not misleading or deceptive. It should be accurate and concise, up-to-date, and easy for patients to understand. Physicians using medical websites should strive to ensure that information provided is, whenever possible, supported by current medical peer-reviewed literature, emanates from a recognized body of scientific and clinical knowledge and conforms to minimal standards of care. It should clearly indicate whether it is based upon scientific studies, expert consensus, professional experience or personal opinion.

How these ethical standards relate to the proper use of social media by physicians is explored further in the next section.

Section Four

Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice

The following guidelines are recommended for physicians who use social media and social networking in their personal and professional lives.

Interacting with Patients

Physicians are discouraged from interacting with current or past patients on personal social networking sites such as Facebook. Physicians should only have online interaction with patients when discussing the patient's medical treatment within the physician-patient relationship, and these interactions should never occur on personal social networking or social media websites. In addition, physicians need to be mindful that while advanced technologies may facilitate the physician-patient relationship, they can also be a distracter which may lessen the quality of the interactions they have with patients. Such distractions should be minimized whenever possible.

Discussion of Medicine Online

Social networking websites may be useful places for physicians to gather and share their experiences, as well as to discuss areas of medicine and particular treatments. These types of professional interactions with other physicians represent an ancillary and convenient means for peer-to-peer education and dialogue. One current example is Doximity, a professional network with more than 567,000 U.S. physician members in 87 specialties. Using Doximity, physicians are said to be able to exchange HIPAA-compliant messages and images by text or fax and discuss the latest treatment guidelines and medical news in their specialty.¹³ While such networks may be useful, it is the responsibility of the physician to ensure, to the best of his or her ability, that professional networks for physicians are secure and that only verified and registered users have access to the information. These websites should be password protected so that non-physicians do not gain access and view discussions as implying medical advice, which may be counter to the physicians' intent in such discussions. Physicians should also confirm that any medical information from an online discussion that they plan to incorporate into their medical practice is corroborated and supported by current medical research.

Privacy/Confidentiality

Just as in the hospital or ambulatory setting, patient privacy and confidentiality must be protected at all times, especially on social media and social networking websites. These sites have the potential to be viewed by many people and any breaches in confidentiality could be harmful to the patient and in violation of federal privacy laws, such as HIPAA. While physicians may discuss their experiences in non-clinical settings, they should never provide any information that could be used to identify patients. Physicians should never mention patients' room numbers, refer to them by code names, or post their picture. If pictures of patients were to be viewed by others, such an occurrence may constitute a serious HIPAA violation.

Disclosure

At times, physicians may be asked or may choose to write online about their experiences as a health professional, or they may post comments on a website as a physician. When doing so, physicians must reveal any existing conflicts of interest and they should be honest about their credentials as a physician.

Posting Content

Physicians should be aware that any information they post on a social networking site may be disseminated (whether intended or not) to a larger audience, and that what they say may be taken out of context or remain publicly available online in perpetuity. When posting content online, they should always remember that they are representing the medical community. Physicians should always act professionally and take caution not to post information that is ambiguous or that could be misconstrued or taken out of context. Physician employees of health care institutions should be aware that employers may reserve the right to edit, modify, delete, or review Internet communications. Physician writers assume all risks related to the security, privacy and confidentiality of their posts. When moderating any website, physicians should delete inaccurate information or other's posts that violate the privacy and confidentiality of patients or that are of an unprofessional nature.

Professionalism

To use social media and social networking sites professionally, physicians should also strive to adhere to the following general suggestions:

- Use separate personal and professional social networking sites. For example, use a personal rather than professional e-mail address for logging on to social networking websites for personal use. Others who view a professional e-mail attached to an online profile may misinterpret the physician's actions as representing the medical profession or a particular institution.
- Report any unprofessional behavior that is witnessed to supervisory and/or regulatory authorities.
- Always adhere to the same principles of professionalism online as they would offline.
- Cyber-bullying by a physician towards any individual is inappropriate and unprofessional.
- Refer, as appropriate, to an employer's social media or social networking policy for direction on the proper use of social media and social networking in relation to their employment.

Medical Board Sanctions and Disciplinary Findings

State medical boards have the authority to discipline physicians for unprofessional behavior relating to the inappropriate use of social networking media, such as:

- Inappropriate communication with patients online
- Use of the Internet for unprofessional behavior
- Online misrepresentation of credentials

- Online violations of patient confidentiality
- Failure to reveal conflicts of interest online
- Online derogatory remarks regarding a patient
- Online depiction of intoxication
- Discriminatory language or practices online

State medical boards have the option to discipline physicians for inappropriate or unprofessional conduct while using social media or social networking websites with actions that range from a letter of reprimand to the revocation of a license.

Future Changes

The Federation of State Medical Boards recognizes that emerging technology and societal trends will continue to change the landscape of social media and social networking, and how these websites are used by patients and physicians will evolve overtime. These guidelines are meant to be a starting point for the discussion of how physicians should properly communicate with their patients using social media. These guidelines will need to be modified and adapted in future years as technology advances, best practices emerge, and opportunities for additional policy guidance are identified.

Section Five

Key Definitions and Glossary

Blog - Blog is a word that was created from two words: "web log". Blogs are usually maintained by an individual with regular entries of commentary, descriptions of events, or other material such as graphics or video. Entries are commonly displayed in reverse-chronological order. "Blog" can also be used as a verb, meaning to maintain or add content to a blog.

Bridging – Bridging can refer to the function patient networking sites serve for people living with chronic disease. Social networking for the chronically ill bridges the gap between the restrictive conditions in which they live and access to support groups and other resources that are important for coping and recovery.

Chat - Chat can refer to any kind of communication over the Internet, but traditionally refers to one-to-one communication through a text-based chat application commonly referred to as instant messaging applications.

Comment - A comment is a response that is often provided as an answer of reaction to a blog post or message on a social network. Comments are a primary form of two-way communication on the social web.

E-mail - Electronic mail, commonly called e-mail or email, is a method of exchanging digital messages from an author to one or more recipients. Modern e-mail operates across the Internet or other computer networks.

Facebook - Facebook is a social utility that connects people with friends and others who work, study and live around them. Facebook is the largest social network in the world with more than 800 million users.

Forums - Also known as a message board, a forum is an online discussion site. It originated as the modern equivalent of a traditional bulletin board, and a technological evolution of the dialup bulletin board system.

Hashtag - A hashtag is a tag used on the social network Twitter as a way to annotate a message. A hashtag is a word or phrase preceded by a "#". Example: #yourhashtag. Hashtags are commonly used to show that a tweet, a Twitter message, is related to an event or conference.

Instant Messaging - Instant messaging (IM) is a form of real-time direct text-based communication between two or more people. More advanced instant messaging software clients also allow enhanced modes of communication, such as live voice or video calling.

LinkedIn - LinkedIn is a business-oriented social networking site. Founded in December 2002 and launched in May 2003, it is mainly used for professional networking. As of June 2010, LinkedIn had more than 70 million registered users, spanning more than 200 countries and territories worldwide

New Media - New Media is a generic term for the many different forms of electronic communications that are made possible through the use of computer technology. The term is in relation to "old" media forms such as print newspapers and magazines that are static representations of text and graphics.

Skype - Skype is a free program that allows for text, audio and video chats between users. Additionally, users can purchase plans to receive phone calls through their Skype account.

Social Media - electronic communication through which users create online communities to share information, ideas, personal messages, and other content.

Social Networking - networking using an online service, platform, or site that focuses on building social relations among people who share interests and/or activities.

Texting - Text messaging, or texting, refers to the exchange of brief written text messages between fixed-line phone or mobile phone and fixed or portable devices over a network.

Tweet - A message or update that one posts on Twitter.

Twitter - Twitter is a platform that allows users to share 140-character-long messages publicly. User can "follow" each other as a way of subscribing to each others' messages. Additionally, users can use the @username command to direct a message towards another Twitter user.

Webinar - A webinar is used to conduct live meetings, training, or presentations via the Internet.

Wiki - A wiki is a website that allows the easy creation and editing of any number of interlinked web pages via a web browser, allowing for collaboration between users.

Wikipedia - Wikipedia is a free, web-based, collaborative, multilingual encyclopedia project supported by the non-profit Wikimedia Foundation.

Yelp - Yelp is a social network and local search website that provides users with a platform to review, rate and discuss local businesses and services.

YouTube - YouTube is a video-sharing website on which users can upload, share, and view videos.

For a more detailed glossary of social media terms, see the link below.

<http://blog.hubspot.com/blog/tabid/6307/bid/6126/The-Ultimate-Glossary-101-Social-Media-Marketing-Terms-Explained.aspx>

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Further Reading

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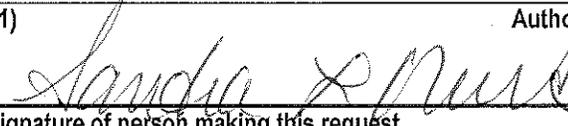
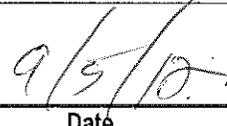
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**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Sandy Nowack Legal Counsel		2) Date When Request Submitted: September 5, 2012 Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: September 19, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? MED10, Discussion Item, Prescribing	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: The Board will discuss prescribing within the code of unprofessional conduct in anticipation of a vote during the October meeting. Will require drafting request to legal counsel.			
11) Authorization <div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center;">  Signature of person making this request </div> <div style="text-align: center;">  Date </div> </div>			
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Board Services Bureau Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

CURRENT LAW PERTAINING TO PRESCRIPTION OF AMPHETAMINES, STEROIDS and ANORECTICS

(r) Conviction of any crime which may relate to practice under any license, or of violation of any federal or state law regulating the possession, distribution, or use of controlled substances as defined in s. 961.01 (4), Stats. A certified copy of a judgment of a court of record showing such conviction, within this state or without, shall be presumptive evidence thereof.

(s) Prescribing, ordering, dispensing, administering, supplying, selling, or giving any amphetamine or sympathomimetic amine drug designated as a schedule II controlled substance to or for any person except for any of the following:

1. Use as an adjunct to opioid analgesic compounds for treatment of cancer-related pain,
2. Treatment of narcolepsy,
3. Treatment of hyperkinesia,
4. Treatment of drug induced brain dysfunction,
5. Treatment of epilepsy,
6. Differential diagnostic psychiatric evaluation of depression,
7. Treatment of depression shown to be refractory to other therapeutic modalities,
8. Clinical investigation of the effects of such drugs or compounds in which case an investigative protocol therefore shall have been submitted to and reviewed and approved by the board before such investigation has been begun.

(x) Prescribing, ordering, dispensing, administering, supplying, selling or giving any anabolic steroid for the purposes of enhancing athletic performance or for other nonmedical purposes.

(zb) Prescribing, ordering, dispensing, administering, supplying, selling or giving any anorectic drug designated as a schedule III, IV or V controlled substance for the purpose of weight reduction or control in the treatment of obesity unless each of the following conditions is met:

1. The patient's body mass index, weight in kilograms divided by height in meters squared, is greater than 25.
2. A comprehensive history, physical examination, and interpreted electrocardiogram are performed and recorded at the time of initiation of treatment for obesity by the prescribing physician.
3. A diet and exercise program for weight loss is prescribed and recorded.
4. The patient is weighed at least once a month, at which time a recording is made of blood pressure, pulse, and any other tests as may be necessary for monitoring potential adverse effects of drug therapy.
5. No more than a 30-day supply of drugs is prescribed or dispensed at any one time.
6. No drugs are prescribed or dispensed for more than 90 days unless all of the following occur:
 - a. The patient has a recorded weight loss of at least 12 pounds in the first 90 days of therapy.
 - b. The patient has continued progress toward achieving or maintaining a target weight.
 - c. The patient has no significant adverse effects from the prescribed program.
7. Any variance from the foregoing requirements is justified by documentation in the patient's record.

WORK GROUP recommendation; eliminate requirements pertaining to any particular medication:

Prescribing, ordering, dispensing, administering, supplying, selling or giving any prescription medication in any manner that is inconsistent with the standard of minimal competence and which creates an unacceptable risk of harm to the patient. The act of presigning a blank, undated or predated prescription form is a violation of this subsection.

FSMB Regarding Prescribing:

21. prescribing, selling, administering, distributing, ordering or giving any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug for other than medically accepted therapeutic purposes.

22. knowingly prescribing, selling, administering, distributing, ordering or giving to a habitual user or addict or any person previously drug dependent, any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug, except as otherwise permitted by law or in compliance with rules, regulations or guidelines for use of controlled substances and the management of pain as promulgated by the Board.

24. violating any state or federal law or regulation relating to controlled substances.

25. signing a blank, undated or predated prescription form.

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: DSPS		2) Date When Request Submitted: 8/17/2012 Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: September 19, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Report from Wisconsin Medical Society Legislative Council Meeting Presentation by Dr. Vasudevan – September 6, 2012	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? (name) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Receive report from Dr. Vasudevan.			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Mary Jo Capodice		2) Date When Request Submitted: _____	
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: September 19, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? AAOE Meeting	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? (name) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required: _____	
10) Describe the issue and action that should be addressed: Consider a motion to authorize Dr. Capodice to attend the AAOE Meeting on October 8.			
11) Authorization			
Signature of person making this request			Date
Supervisor (if required)			Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date



2011-2012 Officers

Dana Shaffer, DO President

Geraldine O'Shea, DO Vice-President

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James Andriole, DO Immediate Past President

August 9, 2012

Mary Jo Capodice, DO Wisconsin Medical Examining Board 1400 E. Washington St. Madison, WI 53703

Dear Dr. Capodice:

Congratulations on your appointment to the Wisconsin Medical Examining Board. On behalf of the American Association of Osteopathic Examiners (AAOE), I would like to take this opportunity to let you know that as a member of a State Board, you are automatically a Fellow of the AAOE.

Established through its Constitution and Bylaws in 1961, the AAOE is a non-practice affiliate of the American Osteopathic Association (AOA). The AAOE provides a forum for osteopathic physicians serving on state licensing boards to network with fellow osteopathic board members and advocates for the osteopathic profession - its education, training and credentialing - within the Federation of State Medical Boards (FSMB). The AAOE also holds an Annual Summit, where CME is offered for Fellows who participate in discussions on issues impacting medical licensure and regulation.

The AAOE enjoys strong collegial and financial support from the AOA and the National Board of Osteopathic Medical Examiners (NBOME), whose efforts consistently contribute to our excellent Summit meeting held each January, as well as our two other regularly scheduled business meetings held during the Annual Meeting of the FSMB in the spring and the AOA Convention in the fall. We hope you will make plans to join us as at all three of these meetings.

One dynamic part of our mission is to speak as the unified authority in matters that affect osteopathic medical licensure and discipline. Currently we enjoy strong representation of AAOE Fellows in leadership positions of the FSMB, including the Board of Directors and committee membership; as well as on the AOA's Bureau of State Government Affairs, Bureau on International Osteopathic Medical Education and Affairs; and the NBOME Board of Directors and committees.

I know you may be in a steep learning curve at this time. You are attempting to treat licensees that come before you with due process, while at the same time keeping protection of the public always in the forefront of your decision-making. By actively participating in the AAOE, I am confident your role as a medical regulator will be enhanced.

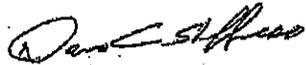
The AAOE has a voting seat for one osteopathic physician from every Board in the country that licenses osteopathic physicians. The AAOE will also reimburse one DO from each state board for two nights housing and economy airfare for attendance at its Annual Summit. I encourage you to speak with your board to determine who will hold

this seat and attend our upcoming meetings. Please note that our next meeting will be held on Monday, October 8, 2012 from 2:30 - 4:00 PM in conjunction with the AOA's Osteopathic Medical Conference and Exposition in San Diego, CA.

Please complete the attached form and return to Nicholas A. Schilligo, MS, Director of State Government Affairs at the AOA. He can also be reached at (800) 621-1773 ext. 8185 or nschilligo@osteopathic.org.

If you have any questions about AAOE or about serving on your Board, please do not hesitate to contact me.

Fraternally,



Dana C. Shaffer, DO, FACOFP
President, AAOE

CC: Ray E. Stowers, DO, FACOFP *dist.*, AOA President
Norman E. Vinn, DO, AOA President-elect
Geraldine O'Shea, DO, Vice-President, AAOE
Scott Steingard, DO, Secretary-Treasurer, AAOE
James Andriole, DO, Immediate Past President, AAOE
John Gimpel, DO, MEd, President and CEO, National Board of Osteopathic Medical Examiners
John B. Crosby, JD, AOA Executive Director
Sydney Olson, AOA Associate Executive Director, Advocacy and Government Relations
Linda Mascheri, Director, AOA Department of State, Affiliate and International Affairs
Nicholas A. Schilligo, MS, Director, AOA Division of State Government Affairs, AAOE Staff Liaison

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Dr. Sheldon Wasserman, M.D. Board Chair		2) Date When Request Submitted: September 6, 2012 Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: September 19, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? FSMB Board Attorney Workshop	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Move to request that the Department authorize board legal counsel to attend the FSMB Board Attorneys Workshop on November 1-2, 2012, based on the program's relevance to the Board's legal work. Please note: This should be viewed as a request only; authority to approve out-of-state travel and training for Department staff lies within the Department..			
11) Authorization			
Signature of person making this request		Date	<i>Dr. Sheldon Wasserman, M.D.</i> <i>9/6/12</i>
Supervisor (if required)		Date	<i>by SW</i> <i>9/6/12</i>
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Board Services Bureau Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			



FSMB Board Attorneys Workshop

November 1-2, 2012

InterContinental New Orleans Hotel
New Orleans, Louisiana

DRAFT AGENDA

*Times and session titles are subject to change

THURSDAY, NOVEMBER 1, 2012

- 8:00 a.m. **Continental Breakfast**
- 8:30 – 8:45 a.m. **Welcome & Introductions**
- 8:45 – 9:45 a.m. **General Session**
"Federal and State Legislative Update - 2012"
Lisa Robin, MLA
Chief Advocacy Officer, FSMB
- 9:45 – 10:15 a.m. **Break**
- 10:15 – 11:30 a.m. **General Session: Panel Discussion**
"Survey of Pain Management Legislation"
Moderator: C. Lloyd Vest, JD, General Counsel, Kentucky Board of
Medical Licensure
Faculty: Kimberly C. Anderson, Esq., State Medical Board of Ohio
James P. McLaughlin, JD, Staff Attorney, Washington Medical
Quality Assurance Commission
- 11:30 a.m. – 12:45 p.m. **Lunch (provided)**
- 12:45 – 1:45 p.m. **General Session: Ethics Session**
- 1:45 – 2:05 p.m. **Break**
- 2:05 – 3:05 p.m. **General Session**
"Medical Spas: The Legal and Regulatory Considerations"
Mari Robinson, JD, Executive Director, Texas Medical Board
Kelli J. Stevens, JD, General Counsel, Kansas State Board of Healing
Arts

3:05 – 3:30 p.m. **Break**
3:30 – 4:30 p.m. **States of the States**
4:30 p.m. **Adjournment**

FRIDAY, NOVEMBER 2, 2012

7:45 a.m. **Continental Breakfast**

8:15 – 9:15 a.m. **General Session**
"Federal Trade Commission (FTC) Investigations"
Thom Mansfield, JD, Legal Director, North Carolina Medical Board

9:15 – 9:30 a.m. **Break**

9:30 – 10:30 a.m. **General Session**
"E-Discovery and Electronic Medical Records in the Digital Age"
Kelli J. Stevens, JD, General Counsel, Kansas State Board of Healing Arts

10:30 – 10:45 a.m. **Break**

10:45 – 11:45 a.m. **General Session**
"Social Media: Changing the Way Lawyers Prosecute"
Mari Robinson, JD, Executive Director, Texas Medical Board

11:45 a.m. – 12:40 p.m. **Lunch (provided)**

12:40 – 1:40 p.m. **General Session**
"Best and Worst Practices in Drafting Motions"
Thom Mansfield, JD, Legal Director, North Carolina Medical Board
Kelli J. Stevens, JD, General Counsel, Kansas State Board of Healing Arts

1:40 – 2:00 p.m. **Break**

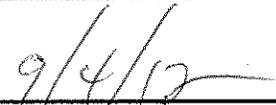
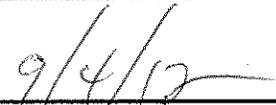
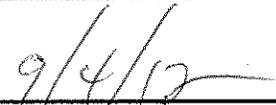
2:00 – 3:00 p.m. **General Session**
"National Practitioner Data Bank Reporting and Compliance Activities"
Mari Robinson, JD, Executive Director, Texas Medical Board

3:00 p.m. **Adjournment**

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Sandy Nowack Legal Counsel		2) Date When Request Submitted: September 4, 2012 Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 													
3) Name of Board, Committee, Council, Sections: Medical Examining Board															
4) Meeting Date: Sept. 9, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? INFORMATIONAL ITEM: Licensure requirements for anesthesiologist assistants, effective November 1, 2012													
7) Place Item in: <input type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:													
10) Describe the issue and action that should be addressed: Website FAQ to address licensure requirements for anesthesiologist assistants. The new Council on Anesthesiologist Assistants will serve the Medical Examining Board in an advisory capacity. See Wis. Stat. 15.407(7).															
<table style="width: 100%; border: none;"> <tr> <td style="width: 10%; border: none;">11)</td> <td style="width: 60%; border: none; text-align: center;"> Authorization  </td> <td style="width: 30%; border: none; text-align: center;">  </td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">Signature of person making this request</td> <td style="border: none;">Date</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">Supervisor (if required)</td> <td style="border: none;">Date</td> </tr> <tr> <td style="border: none;"></td> <td colspan="2" style="border: none;">Bureau Director signature (indicates approval to add post agenda deadline item to agenda) Date</td> </tr> </table>				11)	Authorization 			Signature of person making this request	Date		Supervisor (if required)	Date		Bureau Director signature (indicates approval to add post agenda deadline item to agenda) Date	
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State of Wisconsin
DEPARTMENT OF
SAFETY AND
PROFESSIONAL SERVICES
Dave Ross, Secretary



Anesthesiologist Assistants New Requirements for Licensure
Web Posted: 8/23/2012

NEW REQUIREMENTS FOR LICENSURE AS ANESTHESIOLOGIST ASSISTANTS EFFECTIVE NOVEMBER 1, 2012:

The licensure requirements for anesthesiologist assistants established by 2011 Wisconsin Act 160 become effective on November 1, 2012. The text of the Act may be found here:
<http://docs.legis.wisconsin.gov/2011/related/acts/160>

Who is required to be licensed as an anesthesiologist assistant? Licensure is required for any person who practices as an anesthesiologist assistant, who holds themselves out as one authorized to practice as an anesthesiologist assistant or who uses the letters "A.A." or any other designation that tends to represent the person as an anesthesiologist assistant.

What are requirements for initial licensure: Requirements for initial licensure are: a bachelor's degree, satisfactory completion of an anesthesiologist assistant program that is accredited by the Commission on Accreditation of Allied Health Education Programs (or by a predecessor or successor entity), and a successful score on the certification examination administered by the National Commission on Certification of the Anesthesiologist Assistants.

Are there provisions for reciprocal licensure of anesthesiologist assistants? Yes. The Medical Examining Board *may* grant licenses, without additional examination, to a qualified applicant who is licensed in any state or territory of the United States or the District of Columbia if the license from the other jurisdiction authorizes the applicant to practice in the same manner and to the same extent as authorized in Wisconsin pursuant to Wis. Stat. § 448.22(2).

What are the supervision requirements for an anesthesiologist assistant? Anesthesiologists assistants may practice **ONLY** under the direct supervision of a supervising anesthesiologist in accordance with Wis. Stat. § 448.22, including a written supervision agreement, which must be reviewed annually and maintained continuously on the anesthesiologist assistant's practice site. The supervision agreement document must be available for review upon request. Currently, an anesthesiologist may supervise no more than four anesthetists (including anesthesiologist assistants) at any one time.

What is the scope of practice for anesthesiologist assistants? The scope of practice of an anesthesiologist assistant is limited to that set out in § 448.22(5), unless the supervising anesthesiologist imposes additional restrictions on the scope of practice of any licensee.

What are requirements for renewal of a license to practice as an anesthesiologist assistant? Licenses to practice as an anesthesiologist assistant expire on October 1 of even-numbered calendar years. The first date upon which a Wisconsin license to practice as anesthesiologist assistant expires is October 1, 2014. Upon application for renewal of a

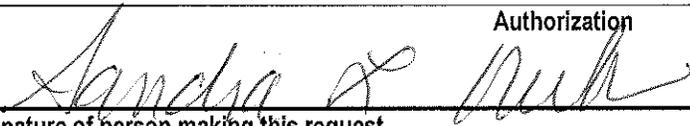
license to practice as an anesthesiologist assistant, the licensee is required to certify that the licensee has met requirements for recertification by the National Commission on Certification of Anesthesiologist Assistants, *including any continuing education requirements.*

Printed Tuesday, September 04, 2012

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

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3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: September 19, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? MED10, INFORMATIONAL ITEM, Stakeholder Comments and Responses	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:			
11) Authorization <div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center;">  <hr/> Signature of person making this request </div> <div style="text-align: center;">  <hr/> Date </div> </div> <hr/> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;">Supervisor (if required)</div> <div style="width: 30%;">Date</div> </div> <hr/> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;">Bureau Director signature (indicates approval to add post agenda deadline item to agenda)</div> <div style="width: 30%;">Date</div> </div>			
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Board Services Bureau Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

WISCONSIN HOSPITAL ASSOCIATION, INC.

August 30, 2012

Sheldon Wasserman, MD
Chair, Medical Examining Board
Wisconsin Department of Safety and Professional Services
1400 East Washington Avenue, Room 112
Madison, WI 53703



Subject: Continuing comments on proposed provisions in MED 10

Dear Dr. Wasserman:

The Wisconsin Hospital Association appreciates the opportunity to comment on changes the Medical Examining Board is considering to MED 10, the administrative rule defining unprofessional conduct for physicians. WHA has the following comments on the proposed agenda items we received on August 27, 2012. Please understand that these are preliminary comments; WHA looks forward to contributing to the MED 10 discussions as the MEB writes proposed rule language and when the proposed rule language can be reviewed in its entirety.

Informed consent:

As discussed at last meeting and described in our previous letter, WHA urges the MEB to cross-reference the informed consent statute s. 448.30 for this provision in MED 10 in order to help ensure the regulation and the statute remain consistent. The agenda item does not indicate this option.

Business practices:

WHA supports language proposed by the Wisconsin Medical Society. None of the options provided in the agenda item, including the option labeled "WMS," accurately reflects the WMS proposal.

Self-report of practice limitations:

WHA urges the MEB to protect local peer review. As we outlined in our previous letter and discussed at the last MEB meeting, WHA is concerned that the self-report proposals would weaken local peer review. We ask the MEB, instead, to advocate for clarifying language in Ch. 50 that would require hospitals to report simultaneously to the MEB and the National Practitioner Data Bank those actions that are reportable to the NPDB.

WHA also is concerned that the piecemeal approach to considering different provisions of MED 10 could put important programs, like local peer review, inadvertently at risk. For example, on page 4,¹ MED 10 should better outline the MEB's authority to investigate, including its subpoena authority. (We would like to understand the MEB's position on the

¹ WHA used the WMS redlined document distributed at the August 15, 2012, meeting of the MEB as its reference document. Page numbers refer to that document.

limitations of that authority.) On page 7, there is a duty to report voluntary agreements to limit, restrict, or relinquish the practice of medicine. In addition, on page 9 there is provision that would make it unprofessional conduct to fail to cooperate in a timely manner with the MEB's investigation of a complaint. The MEB's language also expands the scope of a physician's duty to report to include additional information (page 10). There are likely other provisions. Physicians and other practitioners who participate in the local peer review process must be assured that the process is confidential and protected. The legislature has provided that protection and, while the MEB cannot operate contrary to the direction of the legislature, an indication that the MEB might attempt to challenge or encroach on those protections would adversely affect the important process.

Laws related to the practice of medicine:

The MEB proposes a MED 10 provision that would include as unprofessional conduct the violation of certain state and federal laws. WHA supports specificity in the rule and consistency across rules and, therefore, suggests that the Board for this provision use the offenses listed as "serious crimes" for persons who work in health care facilities regulated by the State (including nursing homes, hospitals, and others). After significant debate, the legislature and the regulatory agency found that these crimes in particular should affect the ability of someone to provide care in a facility regulated by the Department of Health Services. (See s. 50.065(1) (e), Stats., and the guidance at this link <http://www.dhs.wisconsin.gov/publications/p0/p00274.pdf>). Health care employers review other offenses on a case-by-case basis.

Other provisions included in the agenda packet:

"Negligence in the practice of medicine" and several other provisions in this section. Rather than creating a new definition, WHA recommends relying on the civil standard for defining negligence and the statute for other provisions to help ensure consistency. As the Court of Appeals has previously emphasized, "We do not see any reason to depart from the civil standard for medical negligence when determining whether, for disciplinary purposes, a physician was negligent in treating a patient. Wisconsin courts have been developing the civil standard for medical negligence for over a century, and the legislature has provided that "a finding by a court that a physician has acted negligently in treating a patient is conclusive evidence that the physician is guilty of negligence in treatment." Section 448.02(3)(b), Stats. We would create inconsistency and confusion in the board's application of the "negligence in treatment" standard were we to define "negligence in treatment" to mean anything other than medical negligence as defined by Wisconsin's courts."

Thank you, again, for providing the opportunity to comment on proposals during this important process. We look forward to the ongoing dialogue.

Sincerely,



Judy Warmuth
Vice President for Workforce Development



Laura Leitch
Senior Vice President and
General Counsel

WMS Comments, August 30, 2012

INFORMED CONSENT

At the August MEB meeting we heard some members' desire to have a simple definition cross-referencing the current state statute related to informed consent: s.448.30. As we said at the meeting, such a cross-reference accomplishes multiple goals: allowing clarity for physicians in knowing that MED 10 will have the same definition as the statutes, and allowing the code to evolve along with the statutory language if there are changes to the law. Giving a choice to the MEB that includes other language does not respond to some MEB members' concerns that phrases such as "health care service" and the potential broad definition of "medical act" could confuse rather than clarify the informed consent issue.

We believe the agenda could more clearly lay out the option for a simple cross-reference to the statute.

BUSINESS PRACTICES

The language listed as coming from the Society (#2) does not reflect the language in the memo we provided to the MEB in July. The actual language can be found on the bottom third of page 4 of our memo, continuing onto the first three lines of page 5. The agenda language also excluded a phrase we believe is very important as the nation moves toward health care payment reform: "unless allowed by law" needs to remain in our submitted language, as we believe entities such as Accountable Care Organizations (ACOs) will make future structure of health care payments different than what we see today.

SELF-REPORTING/PEER REVIEW

When this issue came before the MEB last month, I emphasized at the onset that the Society was retracting its original suggested language, due to the "possible legal argument" as Ms. Nowak accurately put it that any physician self-reporting an action taken against him/her as a result of peer review could be compelled to release any peer review materials to the MEB. Because of this line of argument and the Society's firm commitment to protecting peer review deliberations, the Society should not have any language listed under the possible options for language changes in this area.

The Society does support a proposal raised in the August 15, 2012 letter from the Wisconsin Hospital Association related to the timing of hospitals' notification of sanctions lasting longer than 30 days. Reporting such actions to both the MEB and the National Practitioner Data Bank simultaneously would appear to solve the problem of the MEB receiving late notification of disciplines. We believe this proposal should be listed among the options.

We also point out for clarity that the third option listed in the draft agenda for this issue area is NOT the WHA proposal. While both the draft agenda option and the WHA proposal both mention a 30-day time period, they are wholly different: the WHA proposal to mirror NPDB reporting requirements is for "professional review actions that are based on reasons related to professional competence or conduct and that adversely affect clinical privileges for a period of longer than 30 days," while the draft agenda would require blanket notification of ALL adverse actions, "whether final or temporary" within 30 days. We continue to believe that such blanket requirements would quickly turn into an

administrative nightmare for the Board, as even temporary sanctions due to delayed filing of medical records, etc., would potentially fall under this requirement.

It is also important to note more generally that there are many sections of the proposed MED10 that can potentially impact peer review confidentiality, which would reinstate a chilling effect on peer review fewer than two years after the Society and WHA successfully pushed for statutory changes in this area. The Society urges the MEB to allow the provisions of 2011 Act 2 to take effect fully before proposing changes to the Administrative Code.

CRIMES SUBSTANTIALLY RELATED TO THE PRACTICE OF MEDICINE We are uncomfortable with this section's attempt to define "substantially related to the practice of medicine and surgery" in ways that include criminal offenses that seemingly are in no way related to the practice of medicine. We understand what the MEB is attempting to do here - have the ability to find a physician guilty of unprofessional conduct wholly unrelated to medical practice due to the notorious nature of the crime. The Society continues to have philosophical differences with this proposal.

That said, perhaps the MEB would consider using an already-existing set of offenses already used by the Department of Health Services under its power to regulate certain health care facilities - this can be found at <http://www.dhs.wisconsin.gov/publications/p0/p00274.pdf>. This would be another area where the MEB could find consistency between a proposed MED10 change and already-existing language elsewhere in law.

OTHER PROVISIONS

This portion of the draft agenda appears to match language provided by the Society to the MEB in the July 11, 2012 memo. In our Monday meeting, however, WHA raised some potential concerns about some of the language, including potential effect on peer review law. If any proposed language in this section could be deemed as impacting 2011 Act 2 protections, the Society would certainly join with WHA in opposing any erosion of the new law.

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

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4) Meeting Date: September 19, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? MED10, INFORMATIONAL ITEM Law pertaining to peer review.	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: INFORMATIONAL ITEM			
11) Authorization			
Signature of person making this request		Date	
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STATUTES PERTAINING TO CONFIDENTIALITY OF PEER REVIEW AND REPORTING TO THE MEB

50.36 Rules and standards. (3)...

(b) If, as a result of peer investigation or written notice thereof, a hospital staff member who is licensed by the medical examining board or podiatry affiliated credentialing board, for any *reasons that include the quality of or ability to practice*, loses his or her hospital staff privileges, has his or her hospital staff privileges reduced or resigns from the hospital staff, the hospital shall so notify the medical examining board or podiatry affiliated credentialing board, whichever is applicable, *within 30 days after the loss, reduction or resignation takes effect*. Temporary suspension due to incomplete records need not be reported.

(c) If, as a result of peer investigation or written notice thereof, a hospital staff member who is licensed by the medical examining board or podiatry affiliated credentialing board, *for reasons that do not include the quality of or ability to practice*, loses his or her hospital staff privileges for 30 days or more, has his or her hospital staff privileges reduced *for 30 days or more* or resigns from the hospital staff for 30 days or more, *the hospital shall so notify* the medical examining board or podiatry affiliated credentialing board, whichever is applicable, *within 30 days* after the loss, reduction or resignation takes effect. Temporary suspension due to incomplete records need not be reported.

NOTES:

Reports concerning loss of privileges are the responsibility of "a hospital".

- The MEB does not have authority over hospitals.
- The MEB does have authority over licensed physicians who aid or abet law violations related to the practice of medicine and surgery. Whether or not the Division would be able to prove that any physician administrator aided and abetted a violation of 50.36, and therefore, Wis. Admin. Code § MED 10.02(2)(z) would be at the discretion of the prosecutors and the Board.

MED 10.02(2)(z) states: Violating or aiding and abetting the violation of any law or administrative rule or regulation the circumstances of which substantially relate to the circumstances of the practice of medicine.

If the peer review results in loss or restriction of privileges concerning quality or ability to practice, the report must be made within 30 days AFTER the loss becomes effective.

- The timing of the required report is not related to the date of the incident.
- If a physician chooses to contest the limitation/restriction, that may increase the length of time between the incident and the report to the Board.
- If a restriction or suspension is less than 30 days, the required report could permissibly be made after the physician's privilege restriction was reinstated.
- Temporary actions concerning quality of care or ability to practice must be reported.

These provisions work together with and do not amend requirements of mandated reporting in Wis. Stat. § 448.115, nor does § 448.115 impact reporting requirements in these sections.

If mandated reporting under § 448.115 is fully complied with, the conduct underlying a restriction of privileges should come to the Board earlier through a mandated report than it would through report of concluded peer review action. Mandated reporting is required whenever a physician has “reasonable belief”, not conclusive proof. Therefore, under mandated reporting, the required reports should come to the Board well before a resultant restriction of privileges comes into effect as is the case of reporting under ch. 50. Even if the Board were to require self-report within 30 days of the notice of suspension, the mandated report should ordinarily come to the MEB well before that date. (The issue of what constitutes a reasonable belief may be subject to interpretation, but it clearly does not require a determination by any convened body or entity. The reporting requirement is personal to the physician witness to the triggering events.)

Section 448.115 requires reporting:

- By licensed physicians;
- Upon reasonable belief (does not require complete investigation);
- Of:
 - A pattern of unprofessional conduct (regardless of dangerousness or the nature of the violation);
 - Immediate or continuing danger to a patient or the public;
 - Physician who is or who may be medically incompetent;
 - Physician who is or may be mentally or physically unsafe to practice.

Section 448.115 does not authorize disclosure of information obtained solely during peer review, but requires disclosure if discovered in any other context, even if the matter was discussed during peer review.

Section 448.115 does not authorize peer review participants other than the physician whose conduct is under review to release the outcome of the review *unless a specific exception applies*.

Exceptions to disclosure of confidential peer review materials are:

- The physician who is the subject of the review authorizes release;
- Upon consent of the physician who is the subject of the review;
- To the person requesting the review SOLELY for purposes of improving quality of care, billing and avoiding improper use of health care services;
- To a court after issuance of a subpoena; and
- To the MEB if the organization or evaluator conducting the review determines that such action is “advisable”;
- Although peer review documents may not be used in civil or criminal proceedings (subject to exceptions that aren’t relevant here), the MEB’s proceedings are administrative and are neither criminal nor civil.
- May be released to the employer of the health care provider, the “parent, subsidiary or affiliate organization of the health care provider” or the “parent, subsidiary or affiliate organization of the health care provider’s employer.

NOTE: Once any peer review documents are released, they do not lose protection under the law. Because this section does not provide for the loss of confidentiality due to disclosure to third parties, no waiver exists under this section. *Ollman v. Health Care Liability Ins. Co.* 178 Wis. 2d 648, 505 N.W.2d 399 (Ct. App. 1993).

NOTE: Hospital reports under § 50.36(3)(c) impose additional requirements on the Board. Before the Board imposes discipline, the Board shall consider whether a licensee has sufficiently improved his or her conduct (which is typical) and if so, the Board shall remove the *report* from the record. (Not applicable to licensees who are disciplined). If no report about the licensee at issue is filed for two consecutive years, the licensee may petition the board to remove any prior reports *that did not result in disciplinary action*. The law does not specify that the report must be removed, but permits the licensee to petition the Board and would require the Board to give due process to the request. Finally, upon request of a hospital the Board must release information pertaining to loss, reduction or suspension of staff privileges from other hospitals and all information relating to the licensee's being found guilty of unprofessional conduct.

448.02 (7) HOSPITAL REPORTS.

(a) Within 30 days of receipt of a report under s. 50.36 (3) (c), the board shall notify the licensee, in writing, of the substance of the report. The licensee and the licensee's authorized representative may examine the report and may place into the record a statement, of reasonable length, of the licensee's view of the correctness or relevance of any information in the report. The licensee may institute an action in circuit court to amend or expunge any part of the licensee's record related to the report.

(b) If the board determines that a report submitted under s. 50.36 (3) (c) is without merit or that the licensee has sufficiently improved his or her conduct, the board shall remove the report from the licensee's record. If no report about a licensee is filed under s. 50.36 (3) (c) for 2 consecutive years, the licensee may petition the board to remove any prior reports, which did not result in disciplinary action, from his or her record.

448.02(7)(c) (c) Upon the request of a hospital, the board shall provide the hospital with all information relating to a licensee's loss, reduction or suspension of staff privileges from other hospitals and all information relating to the licensee's being found guilty of unprofessional conduct. In this paragraph, "hospital" has the meaning specified under s. 50.33 (2).

448.115 Duty to report. (1) A physician who has *reason to believe* any of the following about another physician shall promptly submit a written report to the board that shall include facts relating to the conduct of the other physician:

(a) The other physician is engaging or has engaged in acts that constitute a pattern of unprofessional conduct.

(b) The other physician is engaging or has engaged in an act that creates an immediate or continuing danger to one or more patients or to the public.

(c) The other physician is or may be medically incompetent.

(d) The other physician is or may be mentally or physically unable safely to engage in the practice of medicine or surgery.

146.38 Health care services review; confidentiality of information.

(1) In this section:

(a) "Evaluator" means a medical director or a registered nurse who coordinates review of an emergency medical services program of a health care provider.

(b) "Health care provider" means any of the following:

146.38(1)(b)1. 1. A person specified in s. 146.81 (1) (a) to (hp), (r), or (s).

2. A facility, association, or business entity, as specified in s. 146.81 (1) (i) to (q) and including a residential care apartment complex, as defined in s. 50.01 (6d).

3. A person working under the supervision of or in collaboration with a person specified in subd. 1.

4. A parent, subsidiary, or affiliate organization of a facility, association, or business entity, as specified in subd. 2.

(bm) "Incident or occurrence report" means a written or oral statement that is made to notify a person, organization, or an evaluator who reviews or evaluates the services of health care providers or charges for such services of an incident, practice, or other situation that becomes the subject of such a review or evaluation.

(c) "Medical director" has the meaning specified in s. 256.01 (11).

(1m) No person who participates in the review or evaluation of the services of health care providers or charges for such services may disclose an incident or occurrence report or any information acquired in connection with such review or evaluation except as provided in sub. (3) or (3m).

(2) All persons, organizations, or evaluators, whether from one or more entities, who review or evaluate the services of health care providers in order to help improve the quality of health care, to avoid improper utilization of the services of health care providers, or to determine the reasonable charges for such services shall keep a record of their investigations, inquiries, proceedings and conclusions. No such record may be released to any person under s. 804.10 (4) or otherwise except as provided in sub. (3) or (3m). No such record may be used in any civil or criminal action against the health care provider or any other health care provider; however, except for incident or occurrence reports or records from other persons, organizations, or evaluators reviewing or evaluating health care providers, information, documents or records presented during the review or evaluation may not be construed as immune from discovery under s. 804.10 (4) or use in any civil or criminal action merely because they were so presented. Any person who testifies during or participates in the review or evaluation may testify in any civil or criminal action as to matters within his or her knowledge, but may not testify as to information obtained through his or her participation in the review or evaluation, nor as to any conclusion of such review or evaluation.

(2m) An incident or occurrence report may not be used in any *civil or criminal* action against a health care provider.

(3) Information acquired in connection with the review and evaluation of health care services shall be disclosed and records of such review and evaluation shall be released, with the identity of any patient whose treatment is reviewed being withheld except as permitted under s. 146.82, in the following circumstances:

(a) To the health care provider whose services are being reviewed or evaluated, upon the request of such provider;

(b) To any person with the consent of the health care provider whose services are being reviewed or evaluated;

(c) To the person requesting the review or evaluation, for use solely for the purpose of improving the quality of health care, avoiding the improper utilization of the services of health care providers, and determining the reasonable charges for such services;

(dm) With regard to an action under s. 895.441, to a court of record after issuance of a subpoena; [and]

(f) To the appropriate examining or licensing board or agency, when the organization or evaluator conducting the review or evaluation determines that such action is advisable.

(3m)

(a) Information acquired in connection with the review and evaluation of health care services may be disclosed, and records of such review and evaluation may be released, in statistical form with the consent of the person authorizing or with the authority to authorize the review or evaluation. Information disclosed or records released under this subsection shall not reveal the identity of any patient except as permitted under s. 146.82.

(b) Information acquired in connection with the review or evaluation of health care services may be disclosed, and the records of such a review or evaluation released, to any of the following persons, with the consent of the person authorizing or with the authority to authorize the review or evaluation:

1. The employer of a health care provider, as defined in sub. (1) (b) 1. and 3.

2. The parent, subsidiary, or affiliate organization of a health care provider, as defined in sub. (1) (b) 2.

3. The parent, subsidiary, or affiliate organization of the employer of a health care provider, as defined in sub. (1) (b) 1. and 3.

(3t) A record described under sub. (2) or an incident or occurrence report disclosed either under sub. (3) or (3m) or in violation of this section remains confidential and may not be used in any civil or criminal action against the health care provider or any other health care provider.

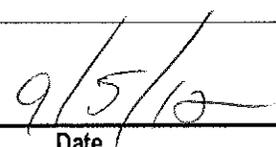
(4) Any person who discloses information or releases a record in violation of this section, other than through a good faith mistake, is civilly liable therefor to any person harmed by the disclosure or release.

(5) This section does not apply to s. 256.25.

(6) Health care provider specific information acquired by an administrative agency in order to help improve the quality of health care, to avoid the improper utilization of services of health care providers, or to determine the reasonable charges for health care services is exempt from inspection, copying, or receipt under s. 19.35 (1).

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Sandy Nowack Legal Counsel		2) Date When Request Submitted: September 5, 2012 Items will be considered late if submitted after 4:30 p.m. and less than: ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: September 19, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? MED10, Informational item, social media	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Journal Sentinel article on physician ethics in social media.			
11) Authorization <div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center;">  Signature of person making this request </div> <div style="text-align: center;">  Date </div> </div>			
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda) Date			
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Board Services Bureau Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

Doctors grapple with ethics of social media

Facebook, Tiwtter offer opportunities, but also dilemmas

By Carol M. Ostrom, The Seattle Times
Aug. 27, 2012

To really get a patient's attention, say doctors, you must start from where they are.

And where they are these days may be on their phone or computer, tweeting, texting, posting on Facebook.

But Twitter, blogs and text messaging aren't in the comfort zone of most physicians - even if some of their patients crave that less formal and more accessible relationship.

Wary of laws governing professional conduct and patient privacy, confused by the complicated rules for different social networks and unsure about the consequences of changing how they interact with patients, many have stayed away.

Others, though, have dipped a toe or two into the virtual swirl. And some are pushing for a full-on plunge, saying social-media venues are too powerful to ignore.

"I feel physicians are obligated to be online," says Wendy Sue Swanson, a pediatrician at The Everett Clinic who tweets and blogs as Seattle Mama Doc. "If celebrities are going to be online, then we educated, practicing physicians had better be there, too."

Credible health information is now often overwhelmed by sales pitches or compelling stories from movie stars who confuse anecdote with evidence, Swanson contends.

At a recent conference for health professionals focusing on the "thin ethical line" between professional boundaries and personal interests, Swanson, movie-star pretty herself and well spoken to boot, took the microphone.

"We're losing ground - we're losing our stake. Science is losing voice," she said.

Swanson's approach leaves some doctors nonplused. Many say they want to "partner" with patients and realize doctors can no longer simply pontificate to patients who duly obey.

But Twitter? Blogs? Facebook?

What about patients' privacy, about squeezing time - unpaid, at that - from an already overbooked day, about inadvertent unprofessional slip-ups?

And what if your patients want to "friend" you?

"I think that's just a really icky idea," said John Lantos, another conference speaker and director of the Children's

Mercy Bioethics Center at Children's Mercy Hospital in Kansas City, Mo.

"I don't respond to 'friend' requests from patients," Lantos said. "What if all your patients were asking you to sleep with them? Does this mean I have to? You just say no!"

Still, these tools are too powerful to ignore, Swanson said.

"The technology is changing the way I practice," said Swanson, 38. "It's changing the way I learn and understand, it's changing what I know about health care and about pediatrics."

Now, in real time, she knows what patients are talking about, who is influencing them, and what she needs to do to steer them toward scientific information.

Using social media, she can let families know that a crib setup pictured in a news story is dangerous for a baby, for example, or weigh in on a breast-feeding controversy.

"We have this really great tool to improve our partnership," she told her colleagues at the conference. "This is an incredible space and an incredible opportunity."

For doctors who couldn't imagine "friending" a patient or that the personal-professional boundary could blur to the point it could cause angst on either side, physician Jennifer Kesselheim, co-chair of the ethics advisory committee at Dana-Farber Cancer Institute in Boston, offered a few examples.

In one case, a young doctor bonded with the parents of a child with leukemia. Just before the child was to leave the hospital, the mother asked to "friend" the doctor, who agreed, expecting to see the family again and not wanting to insult them.

A few days later, he saw postings from the mother, including pictures from a bar, drinking to celebrate her child's hospital discharge.

TMI might well change the doctor's relationship with the family, Kesselheim noted.

Quick studies

Doctors and medical students, too, have pushed online boundaries.

For medical students who have grown up with Facebook and Twitter, social media may be difficult to do without when they begin their professional lives.

A majority of medical schools surveyed report unprofessional online conduct by students, Kesselheim noted, but most have no social-media policy.

A recent survey found that 90% of state medical boards reported at least one online professional-standards violation by a doctor.

In Rhode Island, an emergency-room doctor was fired for a Facebook post about an unnamed patient.

In some ways, social media present situations not unlike those in a small town, where doctors and patients might meet at church or in the grocery store, and doctors have to decide where the boundaries are.

Chat at the church social?

Attend a patient's funeral?

Go to the family's house for lunch?

Probably no medical groups have had more experience at virtual visits with patients than Group Health Cooperative and Kaiser Permanente, which began secure patient-provider emailing nearly a decade ago.

"Our doctors email patients at home, on vacation, at work; we've gotten very comfortable with it," says physician Ted Eytan, formerly of Group Health and now heading Kaiser's 17,000-physician group.

"It's been a huge change. It encourages physicians and nurses to think about patients in their whole life, not just medical care."

Matt Handley, a family doctor and medical director for quality and informatics at Group Health, says it's not difficult to draw a line.

"I've gone skiing or cycling with patients who are friends," he says, and does "friend" some patients on Facebook.

In both cases, it's only with people he's actually friends with. And like those who counsel "elevator rules," he never, ever, talks about work on his Facebook page, he says.

To be a good doctor takes conversation, Handley says, and at the heart of conversation is a relationship. "The more you understand and know about a patient, the more you can understand what matters for them."

Power in the personal

Surveys show patients, though influenced by celebrities, overwhelmingly trust their doctors for medical information. And some want to know them as people, too.

Years ago, Swanson said, she believed it was unprofessional to answer that frequent question patients ask: "Doctor, what would you do?"

Then she saw actress Jenny McCarthy on "Oprah" espousing a vaccine-autism link, a theory that has since been widely discredited by mainstream medicine. She realized how powerful personal stories are for patients, and now responds.

"They say, 'Dr. Swanson, did your son get his MMR shot on time?'"

"I say 'Yep.' And they say, 'OK, we'll do it.' "

Jen Dyer was practicing as an endocrinologist in Ohio. Infrequent office visits, she found, weren't enough to motivate her young diabetic patients to get a grip on their blood-sugar levels.

But texting? OMG! Another story entirely. With a young medical student, Dyer, now a full-time tech entrepreneur, developed an app to automate weekly texts to patients.

She picked up a "cheeky, fun" name given her by a patient - the "Endogoddess" - as her Twitter handle, and began tweeting out tips, from links to medical articles on current topics to advice for handling insulin during a hot afternoon baseball game.

"I felt like it was part of my ethical duty," Dyer says.

As with many new technologies, said Lantos, the Kansas City doctor, it's not yet clear how social media tools could - or should - be used in patient care.

"As we're using it, we're starting to figure out what it's good for, what it's bad for . . . what the risks and benefits are," he said. "We're starting to learn some lessons, but we're only starting to imagine what the possibilities should be."

Find this article at:

<http://www.jsonline.com/features/health/facebook-friends-with-your-doctor-556fji9-167479435.html>

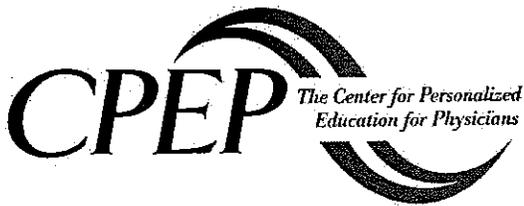
Check the box to include the list of links referenced in the article.

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:	
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: September 19, 2012	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? CPEP Learning Summit – 10/29-30/2012	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? (name) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Consider sending a Board member to this learning summit. Note the agenda is a sample from a past meeting.			
11) Authorization			
Signature of person making this request			Date
Supervisor (if required)			Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date



2012 Learning Summit

October 29 & 30

REGISTRATION FORM

(Name)

(Title)

(Organization/Medical Board)

(Address)

(City, State, Zip)

(Primary Phone)

(Mobile Phone, for communicating while in Denver area)

(Email)

Registrant Role w/ Medical Board
(Check all that apply)

- Board Member
 - Board Executive
 - Board Attorney
 - Board Staff
 - Other (please specify) _____
 - Not Applicable
-

How did you hear about CPEP Learning Summit
(Check one)

- E-mail from CPEP
 - CPEP Website
 - CPEP Booth/ Conference (please specify which conference) _____
 - Postcard or other mailing from CPEP
 - Word of Mouth
 - Other (please specify) _____
-

Have you or anyone from your board/organization attended a CPEP Learning Summit within the past 5 years?
(Check all that apply)

- I have attended within the past 5 years
 - Another representative from my board/organization has attended within the past 5 years
 - This is the first time in the past 5 years someone from my board/organization is attending
 - Unknown
-

Lodging Preference
(Check all that apply)

- Handicap Accessible
- King Bed
- Two Beds
- Additional nights* (at registrant's) # _____
- Other request (specify) _____

* CPEP will cover the expense of one night of lodging at the Holiday Inn Stapleton East or other comparable hotel designated by CPEP. Any additional nights' stay will be at registrants' expense.

Ground Transportation
(Check one)

- I intend to utilize the complimentary shuttle service provided by CPEP or its designated hotel
 - I intend to provide my own transportation
 - Unknown
-

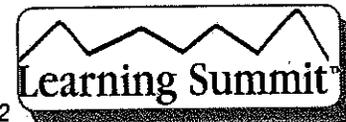
Meal Preference
(Check one*)

- Beef
- Chicken
- Vegetarian

* Registrant will not be held to this selection, this information is only used to gauge number and types of meals.

Return completed form to:
CPEP, The Center for Personalized Education for Physicians
Attention: Gerilyn McGaughan
7351 Lowry Boulevard, Suite #100
Denver, CO 80230
Fax: (303) 577-3241
rsvp@cpepdoc.org

Thank you for joining us at the 2012



sample

Learning Summit™

Monday, August 22, 2011

- 1:00 p.m. **Welcome Reception**
- **Holiday Inn - Conference Room C-1**
 - East wing of the hotel, past the check-in desk and up the stairs to the right
- 1:30 p.m. **Inside CPEP - History, Programs & Principles - Beth Korinek, M.P.H.**
- 2:00 p.m. **Clinical Practice Reentry Program - A Safe Return to Practice After an Extended Leave - Elizabeth Grace, M.D.**
- 2:45 p.m. **Break**
- 3:00 p.m. **Seminars with an Impact - An inside look at CPEP's Patient Care Documentation Seminar & ProBE Program**
- **Documentation Seminar - Holly Elgas, M.D.**
 - **ProBE Program - Elizabeth Grace, M.D.**
- 4:30 p.m. **Real Applications for CPEP**
Participant input and discussion. *Facilitated by Beth Korinek, M.P.H.*
- 5:30 p.m. **Break - E-mail, Telephone, Hotel Check In**
- 6:30 p.m. **Dinner & Networking**
- **Cork House Restaurant**
 - Shuttles will depart from the hotel at 6:30 p.m.

Tuesday, August 23, 2011

- 7:45 a.m. **Shuttle Departs the Holiday Inn for CPEP**
- **Emergency contact: Michelle Wendrych, 303-250-0122**
- 8:00 a.m. **Breakfast at CPEP**
- **Mile High Room**
 - Bagels, muffins, fruit, yogurt, coffee, juice, tea
- 8:30 a.m. **Personalized Process - Putting the 'Personal' into CPEP: A Review of the Individualized Approach to Assessment and Education - Beth Korinek, M.P.H.**

- 9:00 a.m-11:45 a.m. The CPEP Approach to Personalized Assessment and Education**
Rotating, interactive sessions with the CPEP staff - 45 minutes each
- **Structured Clinical Interview (SCI)** - How CPEP Consultants Evaluate Knowledge and Clinical Reasoning - *Elizabeth Grace, M.D., Deborah Presken, M.D.*
 - **Evaluation of Communication Skills** - Observe a Simulated Patient Encounter and Evaluate Physician Communication Skills - *Christopher Leo, Patty Figel, Abby Anderson, M.D.*
 - **Cognitive Screening and Written Testing (Microcog)** - Addressing Physician Cognitive and Health Issues; Review of Written Testing Materials - *Judy Scott*
- 9:00 a.m. 1st Session**
- SCI = Group 1
 - Communication = Group 2
 - Microcog = Group 3
- 9:50 a.m. 2nd Session**
- Communication = Group 1
 - Microcog = Group 2
 - SCI = Group 3
- 10:40 a.m. Break**
- 11:00 a.m. 3rd Session**
- Microcog = Group 1
 - SCI = Group 2
 - Communication = Group 3
- 11:45 a.m. Concrete Steps after the Assessment - Analysis of the Findings and Recommendations of the Final Report - Elizabeth Grace, M.D.**
- Interpreting Individual Assessment Report Findings
- 12:30 p.m. Lunch at CPEP**
- Mile High Room
- 1:15 p.m. Applying Education to Clinical Practice - Effective Educational Interventions – Mary Minobe, Abby Anderson, M.D**
- 2:45 p.m. Break - Refreshments and snacks**
- 3:00 p.m. Wrap up, Questions, Evaluations & Closing Comments - Beth Korinek, M.P.H.**
- 3:30 p.m. Shuttle Pick-up to the Holiday Inn**