



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

Mail to:
PO Box 8935
Madison WI 53708-8935

Email: dsps@wisconsin.gov
Web: <http://dsps.wi.gov>
Phone: 608-266-2112

Governor Scott Walker Secretary Dave Ross

MEDICAL EXAMINING BOARD
Room 121A, 1400 E. Washington Avenue, Madison
Contact: Tom Ryan (608) 266-2112
February 20, 2013

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 description of the actions of the Board.

AGENDA

8:00 A.M.

OPEN SESSION – CALL TO ORDER – ROLL CALL

A. Adoption of Agenda (1-4)

B. 8:00 A.M. APPEARANCE – Jeanette Lytle - DLSC: Discussion and Consideration of Wisconsin State Journal Series Three Part Special Investigation of the Wisconsin Medical Examining Board’s Doctor Discipline (5-66)

C. 8:15 A.M. APPEARANCE – Attorney Arthur Thexton - DLSC: Presentation of Petition for Summary Suspension in Case Number 12 MED 440, Paul Strapon III, M.D.

D. Approval of Minutes (67-76)

E. Secretary Matters

F. Executive Director Matters

- 1) Paperless Initiative (77-78)
- 2) MEB Newsletter (79-80)
- 3) Review of April Meeting Attendance, Screening, and Examination Assignments (81-82)
- 4) Staff Updates

G. DLSC Matters

- 1) **8:45 A.M. APPEARANCE – Patara Horn - Monitoring: Professional Assistance Procedure (PAP) Overview (83-84)**

H. Education and Examination Matters

- 1) Discussion and Consideration of ACGME Post-Graduate Education Requirement (85-86)

I. Legislative/Administrative Rule Matters:

- 1) Current and Future Rule Making and Legislative Initiatives
- 2) Administrative Rules Report
 - a) Chapter MED 8 Update
 - b) Chapter MED 10 Update

J. Practice Matters

- 1) Discussion and Consideration of Position Statements, ALJ Decision, Position Papers
(87-138)

K. 9:15 A.M. APPEARANCE – Chad Zadrazil: PDMP Update (139-140)

L. FSMB Matters

- 1) **Report from FSMB Conference “State Medical Licensure Discipline: Advocacy and Opportunities in 2013 and Beyond” – Ft. Worth, TX – January 16, 17, 2013 (141-148)**

M. Discussion and Consideration of Insurance Company Response to Board Discipline Orders (149-150)

N. Informational Items

- 1) Online Professionalism Investigations by State Medical Boards: First, Do No Harm
(151-160)

O. 11:00 A.M. APPEARANCE – Attorney Sandy Nowack & MED Team Members–DLSC: Introduction to MED/HEALTH Team (161-162)

P. Items Added After Preparation of Agenda:

- 1) Introductions, Announcements and Recognition
- 2) Executive Director Matters
- 3) Education and Examination Matters
- 4) Credentialing Matters
- 5) Practice Matters
- 6) Disciplinary Matters
- 7) Legislation/Administrative Rule Matters
- 8) Informational Items
- 9) Presentation of Proposed Stipulation(s), Final Decision(s) and Order(s)
- 10) Presentation of Proposed Decision(s)
- 11) Presentation of Interim Order(s)
- 12) Petitions for Re-Hearing
- 13) Petitions for Summary Suspension
- 14) Petitions for Assessments
- 15) Petitions to Vacate Orders
- 16) Petitions for Designation of Hearing Examiner
- 17) Requests for Disciplinary Proceeding Presentations
- 18) Motions
- 19) Petitions
- 20) Appearances from Requests Received or Renewed
- 21) Speaking Engagement, Travel, and Public Relation Requests

Q. Screening Panel Report

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

S. Monitoring Matters: (163-164)

- 1) **11:30 A.M. APPEARANCE – Christian Reikersdorfer, M.D. – Requesting Terms/Conditions be Deemed Satisfied**
- 2) **Kristen D. Peterson, M.D. – Requesting Reduction in Drug and Alcohol Screens**
- 3) **John G. Schuetz, M.D. – Requesting Removal of Limitation/Return to Full Licensure**
- 4) **Lawrence J. Williamson, M.D. – Requesting Permission to Apply for Licensure after Surrendering**

T. Summary Suspension(s):

- 1) **Deliberation of Petition for Summary Suspension in Case Number 12 MED 440, Paul Strapon III, M.D. (165-198)**
- 2) **Consideration of Petition for Designation of Hearing Official in Case Number 12 MED 440, Paul Strapon III, M.D. (199-202)**

U. Presentation and Deliberation on Proposed Stipulations, Final Decisions and Orders by the Division of Legal Services and Compliance (DLSC):

- 1) **Charles D. Pratt, M.D. – 12 MED 173 (203-210)**
 - a) Case Advisor: **Timothy Westlake, M.D.**
- 2) **Noemi A. Prieto, M.D. – 12 MED 188 (211-218)**
 - a) Case Advisor: **Sandra Osborn, M.D.**
- 3) **Erik Brekke, M.D. – 12 MED 258 (219-224)**
 - a) Case Advisor: **Timothy Swan, M.D.**
- 4) **Thomas A. Londergan, M.D. – 12 MED 258 (225-232)**
 - a) Case Advisor: **Timothy Swan, M.D.**
- 5) **James J. Young, M.D. – 12 MED 166 (233-238)**
 - a) Case Advisor: **Timothy Westlake, M.D.**
- 6) **Dorothy Novak, M.D. – 12 MED 303 (239-244)**
 - a) Case Advisor: **Suresh Misra, M.D.**

V. Deliberation of Complaints for Determination of Probable Cause:

- 1) **Hanan M. Tosson, M.D. – 11 MED 281 (245-248)**
 - a) Case Advisor: **Jude Genereaux**
- 2) **Carla A. Johnson, D.O. – 12 MED 108 (249-252)**
 - a) Case Advisor: **Rodney Erickson, M.D.**

W. Deliberation of Administrative Warnings:

- 1) **12 MED 076 (253-254)**

X. DLSC Matters:

- 1) **Case Status Report**
- 2) **Case Closing(s)**

Y. Consulting with Legal Counsel

Z. Deliberation of Items Added After Preparation of the Agenda

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

AA. Ratifying Licenses and Certificates

RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION

BB. Vote on Items Considered or Deliberated Upon in Closed Session, if Voting is Appropriate

CC. Open Session Items Noticed Above not Completed in the Initial Open Session

ADJOURNMENT

NEXT MEDICAL EXAMINING BOARD MEETING: 3/20/2013

1:45 P.M.

ORAL EXAMINATION OF CANDIDATES FOR LICENSURE – ROOM 121A,B,C, AND 199B

CLOSED SESSION – Reviewing applications and conducting oral examinations of one (1) candidates for licensure – Drs. Simons, Westlake, Wasserman, and Erickson

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Sheldon Wasserman		2) Date When Request Submitted:	
		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: February 20, 2013	5) Attachments: x Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Wisconsin State Journal Series Three Part Special Investigation of the Wisconsin Medical Examining Board's Doctor Discipline	
7) Place Item in: x 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? Jeanette Lytle, Attorney Supervisor, Division of Enforcement 8:00 a.m.	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Review and Discuss the article series, which is attached. Jeanette Lytle, Attorney Supervisor in the Division of Enforcement, will appear on behalf of the Department.			
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	

Wisconsin doctors who make mistakes often don't face serious consequences

DOCTOR DISCIPLINE: FIRST OF A THREE-PART SPECIAL INVESTIGATION



JANUARY 27, 2013 6:00 AM • DAVID WAHLBERG |
 WISCONSIN STATE JOURNAL |
 DW AHLBERG@MADISON.COM | 608-252-6125

It was a routine procedure.

Dr. David Almasy used an electrified wire to remove abnormal tissue from the cervix of Nicole Johnston, a 35-year-old mother of four. To reduce bleeding, he injected epinephrine.

The consequences were anything but routine. Johnston's heart started racing, her

blood pressure soared and her lungs filled with fluid, causing her to suffocate and die.

During the procedure at Upland Hills Health in Dodgeville in 2010, Almasy gave her at least 100 times too much epinephrine, records show.

The Wisconsin Medical Examining Board in 2011 reprimanded Almasy, required him to take two classes and fined him \$1,200.

"He destroyed my family," said Jaimie Barnes, 18, of Madison, Johnston's daughter. "He should have had his license suspended. I'm baffled he didn't get a higher punishment to fit the crime."

But the medical board's reprimand of Almasy is typical, a State Journal analysis found. The newspaper reviewed all 218 cases leading to medical board discipline from 2010 to 2012, along with dozens of cases in which the board didn't take action.

More than half of the doctors disciplined received reprimands, warnings that go on their records but don't limit their practices.

In at least 50 of the cases involving reprimands, patients died or were harmed, leaving some to wonder why the board didn't order harsher penalties.

The board used the same discipline for doctors who wrote questionable sick notes for protesters at the state Capitol in 2011.

Medical board leaders defended their actions, saying they prefer to rehabilitate doctors rather than punish them, especially for mistakes.

But they also said limited money and authority sometimes prevent the board from taking more serious disciplinary action

"It would be nice to have revocations. It would be nice to have stronger suspensions," said Dr. Sheldon Wasserman, board chairman. "But that comes at a cost. We don't have the resources."

State ranks near bottom

Wisconsin has long ranked near the bottom of states in taking serious actions against doctors, according to the consumer watchdog group Public Citizen.

In the group's latest annual report, in May, the state ranked 46th, up from 49th the previous three years.

Wisconsin's medical board ordered 1.90 serious actions per 1,000 doctors from 2009 to 2011, the latest report found. That's about a third less than top-ranked states.

Wasserman and others say Wisconsin might have better doctors than most states. But Public Citizen said there's no evidence the prevalence of doctors deserving discipline varies substantially among states.

"It's a dysfunctional process," Dan Rottier, a medical malpractice attorney from Madison, said of Wisconsin's medical board. "We tell people never to expect them to do anything."

Rottier's lawsuit against Dr. Leonard Go on behalf of Shelby Bomkamp led to a \$17.3 million settlement in 2009.

Bomkamp — of Highland, northwest of Dodgeville — suffered a permanent brain injury at age 6 during surgery to remove her spleen, according to the lawsuit and medical board records.

During the surgery in 2007 at St. Mary's Hospital in Madison, Go used a blender-like device to chop up her spleen. He accidentally cut major blood vessels and her bowel, records show.

Go, of Dean Clinic, hadn't used the device before, nor had he been trained how to use it.

The medical board reprimanded him in 2011 and fined him \$1,800. The fines are based on investigation costs.

Go declined to comment to the State Journal. In a letter to the medical board, he said he expected to "bear lifelong personal remorse" for what happened.

"I firmly believed the technique I was using in this procedure represented a safer option for the patient," he wrote.

But Rottier said the medical board's discipline wasn't enough.

"A child is permanently brain damaged, and he gets a reprimand? It's pathetic," he said.

Slaps on the wrist?

Wasserman said the board's limited budget makes it hard to fight doctors willing to spend large sums to defend themselves. The board is part of the Wisconsin Department of Safety and Professional Services.

The budget was increased to \$1.8 million in 2009 through a 33 percent increase in doctor license fees.

This year, the budget is \$1.9 million. A \$1.25 million transfer of reserve funds by the state to the general fund last year reduced money available for future years, according to the Legislative Fiscal Bureau.

"There's a push to just get it done with, get the plea bargain accepted and approved, rather than sometimes a harder line," Wasserman said.

The state Supreme Court has ruled the board is supposed to protect the public, deter wrongdoing and rehabilitate doctors — but not punish them, said Dr. Gene Musser, a board member and former board chairman.

State statutes say the board should investigate complaints of unprofessional conduct but don't authorize the board to launch its own probes of suspected wrongdoing, Musser said.

Also, Wisconsin doesn't routinely do criminal background checks when doctors apply for licenses, as most states do.

But a major reason Wisconsin ranks low is the medical board's frequent use of reprimands instead of harsher penalties. Public Citizen doesn't consider reprimands to be serious discipline.

"They are slaps on the wrist," said Dr. Sidney Wolfe, director of Public Citizen's health research group. "They don't have any effect on the doctor's practice."

But Musser said when doctors are reprimanded, the state's 23,000 licensed doctors are notified through a newsletter. Prospective employers find out. So can the public, by searching the medical board's website.

"The process a physician goes through to be reprimanded really wakes them up," Musser said. "It is a gigantic event."

Almasy "showed tremendous remorse" for the epinephrine overdose that killed Johnston, Wasserman said. In a letter to the board from his attorney, Almasy said he was "devastated" by what happened. He declined to comment to the State Journal.

Formerly with Dean Clinic, Almasy lost his privileges at the Dodgeville hospital for nine months and now practices in Sterling, Ill.

He said a nurse gave him the wrong concentration of epinephrine, according to medical board records.

But the nurse, in a deposition, said Almasy confirmed the concentration and dosage before injecting the drug. A surgical tech backed up the nurse's account.

An assessment ordered by the medical board said Almasy needed to work on his listening skills.

"He will live with this for the rest of his life," Wasserman said. "That's a tremendous punishment."

Disciplining doctors, whose work often involves life or death, is different from punishing criminals, Musser said.

"We have people in general who did not mean to do bad," he said. "They are meaning to do good."

An unwanted hysterectomy

Laurel Dean — of Spooner, in northwest Wisconsin — lost her ability to bear children at age 28 after Dr. Neal Melby performed an emergency hysterectomy.

Melby scheduled the surgery in 2005 at Baldwin Area Medical Center. It was needed to stop bleeding from complications of a routine procedure he had done to remove tissue from Dean's uterus, according to medical board records.

Dr. Marvin Klingler asked Melby to do the routine procedure — dilation and curettage, or D&C — after a pelvic ultrasound was "suspicious" for tissue in Dean's uterus.

But pelvic ultrasounds have a high rate of false positives in women who have recently given birth, the medical board said, and Dean had delivered her first baby seven weeks earlier.

Klingler should have considered nonsurgical options, the board said.

Klingler told the State Journal his recommendation for a D&C was reasonable, and he discussed the potential risks with Dean.

Dean's lawsuit against Melby, who works in New Richmond, led to a confidential settlement in 2008. Her lawsuit against Klingler, who worked in Baldwin until starting a new job in Hudson this year, went to trial the same year. The jury cleared him of negligence but found Melby negligent. Melby declined to comment.

In 2011, the medical board reprimanded both doctors, ordered each of them to take a class, and fined Melby \$2,400 and Klingler \$850.

Dean said she has a hard time seeing pregnant women and learning that her friends are pregnant. The emotional toll led her and her husband to divorce, she said.

She planned to have at least one more child. Her daughter is 7.

The medical board should have suspended Melby and Klingler and required them to take more classes, Dean said.

"The way it's impacted my life, I feel that it should also have an impact on their lives," she said. "I almost died."

Mad, sympathetic over reprimands

Elsie Nelson, of Two Rivers, went for surgery on the right side of her spine in 2002.

But Dr. Paul Baek operated on the left side, according to medical board records and a lawsuit by Nelson that led to a confidential settlement in 2007.

In 2003, Baek, a neurosurgeon with Aurora Health Care in Green Bay, made the same mistake with another patient, according to the medical board.

The board reprimanded Baek, fined him \$2,500 for both incidents and required him to attend a two-day patient safety workshop. Baek declined to comment.

"I would yank his license for six months," said Robert Nelson, Elsie's husband.

Elsie, 83, said another doctor later operated on her right side but she still has pain.

"It makes you mad that doctors screw up more than once and the population at large doesn't know that," she said.

Roger Schwartz is more sympathetic.

In 2003, he suffered a stroke that left him permanently disabled on his left side, according to medical board records and his lawsuit against Dr. Joel Stoeckeler. The suit led to a confidential settlement in 2008.

Stoeckeler, who works in Baldwin, failed to adequately monitor Schwartz's blood thinner levels, putting him at risk for the stroke, according to the medical board.

Stoeckeler told the State Journal he didn't have access to important home health data for Schwartz, and at least six other doctors were involved. "This was a health information failure, not an individual failure," he said.

The board reprimanded Stoeckeler in 2011, fined him \$1,900 and required him to take courses in blood thinner management.

"He shouldn't have cut me off (the blood thinner drugs) like that. ... I've got to live with it," said Schwartz, 71, a resident of Wisconsin Veterans Home at King, near Waupaca.

But Schwartz said the reprimand was appropriate. "Other people think he's a good doctor," he said.

Epinephrine overdose

To Jaimie Barnes, Almsy's reprimand was insufficient for her mother's epinephrine overdose.

"It's nothing," she said. "He killed my mom."

Johnston, of Barneveld, was working at Madison Family Dental Associates in April 2010 when she had an abnormal Pap smear.

She had also tested positive for HPV, putting her at greater risk for cervical cancer. After another test found abnormal tissue, Almasy recommended a loop electrosurgical excision procedure to remove it. Johnston agreed.

During the low-risk procedure, doctors usually inject epinephrine mixed with lidocaine or Marcaine, drugs that reduce pain. The concentration of epinephrine in such mixtures is 1:100,000 or 1:200,000.

Almasy asked for 20 milliliters of epinephrine to inject into Johnston.

Nurse Brenda MacKinnon asked if he wanted "just epinephrine," according to her deposition. She said she also asked if he wanted 1:1,000.

According to her, he said, "Yes. I use this in the clinic for all my cases in the clinic."

Almasy said he didn't recall MacKinnon specifying 1:1,000.

Education vs. accountability

After Almasy injected the epinephrine, Johnston had a toxic reaction. She was taken to UW Hospital in Madison but could not be revived.

The state Board of Nursing didn't discipline MacKinnon after an investigation found insufficient evidence of wrongdoing.

A lawsuit against Almasy led to an \$885,000 settlement last year for Barnes and her three siblings, now ages 14, 9 and 3. The four children have three fathers, and with Johnston gone, "now we're all separated," Barnes said.

Musser, the former medical board chairman, said medical errors — especially system errors like Almasy's appeared to be — call for re-education, not harsh discipline.

Almasy had no other complaints in Wisconsin.

What happened to Johnston is "horrible," Musser said but the board looks at whether doctors endanger patients and have problematic track records, not at the severity of the outcome of a mistake, he said.

"We could all be revoked if you revoked for error," Musser said. "None of us work error free."

Madison attorney Keith Clifford, who filed the suit against Almasy, said it "shocks the conscience" that the medical board issued its least serious discipline for the most serious harm.

"It's just woefully inadequate," he said. "The health care system is almost rendered unaccountable."

— *David Wahlberg wrote this series while participating in the California Endowment Health Journalism Fellowships, a program of USC's Annenberg School for Communication and Journalism.*

Doctor Discipline three-part special report

Today: Wisconsin rarely suspends or revokes medical licenses, leading some to question if the state does enough to ensure patient safety.

Monday: Even in cases where a jury gives the patient a large award, the state may not take any disciplinary action against the doctor.

Tuesday: Wisconsin Medical Board members say they'd like to be tougher on doctors but don't have the authority or money to do so.

Search for yourself

To check if any doctor has ever been disciplined by the medical board and read about those cases:

1. Go to go.madison.com/doctors.
2. Under profession, select medicine and surgery.
3. Enter a doctor's name and click search.
4. Click on the doctor's name.
5. Click on orders. If any appear, click to read them. If none appear, the doctor hasn't been disciplined.

Findings: Board issued 115 reprimands, suspended 19

The State Journal reviewed all 218 cases leading to discipline by the Wisconsin Medical Examining Board from 2010 to 2012.

The paper also inspected files for dozens of complaints to the medical board or to a separate state agency that mediates malpractice claims. It looked at lawsuits in those and other cases. Many cases didn't result in medical board discipline.

The paper's analysis found that during the three-year period, the medical board:

- Issued 115 reprimands, or warnings that go on doctors' records but don't limit their practice, while restricting the practices of 10 of those doctors and suspending one through additional action.
- Used reprimands for a wide range of problems, from poor record keeping and improper drug prescribing to missed cancer diagnoses and fatal mistakes.
- Gave reprimands in at least 15 cases in which patients died and another 36 in which they were harmed.
- Overall, revoked the licenses of five doctors, suspended 19 doctors and restricted the practices of 24 doctors. Another 30 doctors surrendered their licenses and 11 retired around the time they were being investigated.

Some doctors not disciplined, even following large malpractice settlements

DOCTOR DISCIPLINE: SECOND OF A THREE-PART SPECIAL INVESTIGATION



JANUARY 28, 2013 5:00 AM • DAVID WAHLBERG |
WISCONSIN STATE JOURNAL |
DWAHLBERG@MADISON.COM | 608-252-6125

Every three hours, even at night, Ken Plants dials up his morphine pump and rocks on his therapy ball.

Back and leg pain on his right side came from a work injury, he said. But similar pain on his left side came from surgery by Dr. Cully White, according to a lawsuit settled in 2009 for \$2.9 million.

White was supposed to operate on the right side of Plants' spine in 2004. But he did the procedure on the left side, according to the lawsuit and a complaint before the Wisconsin Medical Examining Board.

Yet, nine years after the surgery and four years after the medical board was notified about the settlement, the board has taken no action against White, who works in Milwaukee.

White is one of at least 21 doctors in Wisconsin who settled malpractice lawsuits for large sums or were found negligent by juries, from 2007 to 2011, who have not been disciplined by the medical board, a State Journal analysis found.

White's case remains open, but most of the other cases are closed.

Plants, 56, a former carpenter from Bristol, near Kenosha, said his pain has kept him from working, hunting, fishing and playing with his children and grandchildren.

He and his attorney were so motivated to have the medical board discipline White that they took an usual step in 2010: filing a court petition seeking action. A judge dismissed it.

"To see him still practicing just kills me," Plants said. "I accept human error, but you've got to admit it."

White declined to comment, other than to say through a spokeswoman that he's cooperating with the medical board's investigation.

In 2009, a jury found Dr. Lorraine Novich-Welter negligent for causing brain damage to Dan Nelson in 2000. She had trouble clearing a clog in his tracheotomy tube at Froedtert Hospital in Milwaukee, depriving him of oxygen, according to medical board records.

The jury awarded \$2.1 million to Nelson, who lives east of Lake Geneva, but the case was later settled without a judgment against Novich-Welter.

In 2011, the medical board decided not to discipline her because she was a resident, or doctor-in-training, at the time of the incident and had no other complaints. She works in Utah and declined to comment.

"I think she should definitely be censured in some form," said Nelson's mother, Jean Nelson. "The judgment of a doctor is essential in a crisis situation."

Negligence but no discipline

Dr. Gene Musser, a medical board member and former board chairman, said the board handles complaints against doctors differently than courts do.

In court, lawyers must show that negligence caused damage with financial implications, he said.

"In our rule, you have to prove that the action created a danger to the patient, and that's it," Musser said. "The outcome is irrelevant."

Autumn Worden was born in 2002 with cerebral palsy and other permanent brain injuries. During her delivery by Dr. Debra Stockwell at Saint Mary's Hospital in Rhinelander, she suffered from a lack of oxygen, according to medical board records.

Fetal heart monitoring showed signs of distress, but Stockwell left the room to do another delivery, the records show. By the time she returned about 40 minutes later, the situation had become worse. She called for an emergency cesarean section but it wasn't done for another hour.

During a trial in 2008, Worden's mother, Nancy, said her daughter, then 6, couldn't crawl, walk, speak or feed herself and would always wear diapers.

The jury found Stockwell negligent and awarded \$4.6 million. An appeal led to a \$4.5 million settlement last year.

In 2011, the medical board decided not to discipline Stockwell, in part because her license expired in 2005. The board sometimes acts in such situations, however. Stockwell, whose last known address was in California, couldn't be reached for comment.

Daniel Tomas, of the Iowa County village of Plain, died four days after Dr. Theodore Parins removed his appendix at Sauk Prairie Memorial Hospital in 2003. Tomas was 45.

An autopsy found torn abdominal tissue and bleeding, apparently from the surgery, according to a complaint filed with the state's Medical Mediation Panel.

In 2009, a jury found Parins negligent and awarded \$1.7 million to Tomas' wife, Doris. An appeal led to a confidential settlement.

In a statement to the State Journal, Parins said the autopsy was incomplete. Tomas likely died from a complication of his appendicitis, not from the surgery, he said.

At discharge, Parins said, he told Tomas to return to the hospital if he had increased pain. But Tomas didn't, despite having bad chest pain the day before he died.

The medical board took no action against Parins. Jury awards and settlements are supposed to automatically generate complaints to the board, but a spokeswoman said the board never received a complaint against Parins.

Sarah Jewell, of Mineral Point, had neck surgery at St. Mary's Hospital in Madison in 2005 on bone spurs that were causing neck, shoulder and arm pain.

She woke up paralyzed on her left side from a spinal cord injury, according to a Medical Mediation Panel complaint. Her lawsuit against Dr. Todd Trier, who performed the surgery, led to a confidential settlement in 2009.

In 2007, Trier operated at St. Mary's on Dennes McCartney, 52, of Linden, northwest of Mineral Point.

Trier was supposed to remove an infected shunt in McCartney's brain. The device had been placed years earlier when McCartney had a tumor removed.

During the surgery to remove the shunt, the device broke and Trier left part of it in, according to a Medical Mediation Panel complaint. A piece removed tested positive for staph bacteria.

Pus started draining from McCartney's inflamed neck. Eventually another doctor operated and found a two-inch fragment of the shunt. After the doctor removed it, McCartney's neck wound healed.

McCartney's lawsuit against Trier in 2011 led to a confidential settlement last year. Trier's shunt removal "conformed with the standard of care," according to a statement by his attorney.

The medical board hasn't disciplined Trier for the Jewell or McCartney cases. The board spokeswoman said the board didn't receive complaints in either case.

In June, Dean Clinic announced that Trier had stopped working there at a neurosurgeon. He couldn't be reached for comment.

No pulse for 11 minutes

Nelson, who won the jury verdict against Novich-Welter, was in a motorcycle accident in 2000. He broke several bones and suffered a traumatic brain injury. He wasn't wearing a helmet.

He was taken to Froedtert, where he had several surgeries before going to the hospital's rehab unit.

On his first morning in rehab, a nurse saw that his tracheotomy tube was clogged, according to medical board records. She called for Novich-Welter, who was unable to clear it. Though a replacement tube was on the wall, Novich-Welter didn't try to change it, records show.

By the time an emergency team removed the clog and revived Nelson, he had gone without a pulse for 11 minutes, according to a Medical Mediation Panel complaint filed by his attorney.

The lack of oxygen caused an additional, permanent brain injury, the complaint says. Also, a condition in which bone develops in soft tissue allegedly was made worse because medications were stopped while he recovered.

"It definitely caused me to be in this wheelchair," said Nelson, 52, who lives in New Munster, between Lake Geneva and Kenosha.

Nelson said he had started walking, with assistance, when he got to rehab.

Though Nelson is not paralyzed, the bone condition — called heterotopic ossification — makes him unable to walk, he and his mother said. His speech is slurred, and his mental capacity is reduced. Home health aides assist him.

Before the accident and the tracheotomy clog, Nelson owned a restaurant in northern Illinois. He and his now ex-wife, who have two children, were runners.

Jean Nelson said the medical board should have at least reprimanded Novich-Welter "so this is on her permanent record."

Dan Nelson said the doctor learned a lesson, even without medical board discipline. "Unfortunately, I paid for it," he said.

Wrong-side surgery

Plants said his pain gets worse throughout each day, though his morphine pump provides some relief.

He can't sleep more than a couple of hours at a time, he said. It's hard for him to sit on a chair or a couch for long. He curls over his therapy ball and rarely leaves the house.

"We don't socialize with people anymore," he said.

He started receiving disability payments in 2006 but also applied unsuccessfully for dozens for jobs, he said.

After White's operation, Plants had three spine surgeries by two other doctors. Those procedures didn't ease his pain much, he said. It's not clear why.

His right leg and lower back initially started hurting after he lifted a heavy bucket at work in July 2003, he said.

White operated in February 2004.

"When I woke up, both legs were bad," Plants said.

An MRI showed that White did the procedure on the left side, according to the complaint against White before the medical board. A doctor who later operated on Plants also said White hadn't operated on the right side.

After the surgery, when Plants told White about his left-side pain, White said it was from how he had been positioned on the operating table, the complaint says. White sent Plants for physical therapy.

In a statement by his attorney, White said the surgery didn't cause Plants any harm.

Plants said he could have received more money from White if he had agreed to keep his settlement confidential. But he wants others to know what happened.

"For him to sit there and lie to me, that's not acceptable at all," he said.

— *David Wahlberg wrote this series while participating in the California Endowment Health Journalism Fellowships, a program of USC's Annenberg School for Communication and Journalism.*

Doctor Discipline three-part special report

Sunday: Wisconsin rarely suspends or revokes medical licenses, leading some to question if the state does enough to ensure patient safety.

Today: Even in cases where a jury gives the patient a large award, the state may not take any disciplinary action against the doctor.

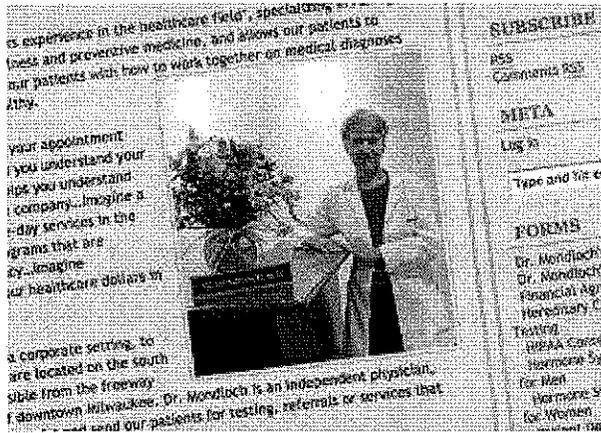
Tuesday: Wisconsin Medical Board members say they'd like to be tougher on doctors but don't have the authority or money to do so.

Search for yourself

To check if any doctor has ever been disciplined by the medical board and read about those cases:

1. Go to go.madison.com/doctors.
2. Under profession, select medicine and surgery.
3. Enter a doctor's name and click search.
4. Click on the doctor's name.
5. Click on orders. If any appear, click to read them. If none appear, the doctor hasn't been disciplined.

Case study: Reprimand didn't end Dr. Victoria Mondloch's problems



JANUARY 28, 2013 7:00 AM • DAVID WAHLBERG |
WISCONSIN STATE JOURNAL |
DWAHLBERG@MADISON.COM | 608-252-6125

Dr. Victoria Mondloch tried to deliver twins vaginally in 2002 despite signs of distress, records show.

The first twin had significant brain injuries. The second was stillborn.

Hospital officials said Mondloch, an obstetrician/gynecologist from Waukesha, should have done a cesarean section, according to the Wisconsin Medical

Examining Board.

She also cut another baby's head during delivery, according to medical board records. In another case, she stripped a woman's membranes to induce labor and sent her home, where her uterus ruptured and the baby died.

The medical board reprimanded Mondloch for the incidents in 2004. It also fined her \$2,000 and ordered her to finish a year-long education program she had started.

Nine months later, the board cleared her license. But the problems didn't end, raising questions about the board's ability to protect the public while trying to rehabilitate doctors.

In 2008, Waukesha Memorial Hospital investigated 23 of Mondloch's patient records from 2005 to 2008 for concerns including inadequate medical skills and poor quality of care. She surrendered her privileges at the hospital in 2009.

Problems with Mondloch's treatment of five patients from 2004 to 2010 led the medical board last year to order her to stop all obstetrics work while the board continues to investigate.

According to a complaint before the medical board, Mondloch:

- Missed an ectopic pregnancy after the patient saw her several times in a month. The patient eventually went to the emergency room, where doctors discovered a ruptured ectopic pregnancy and had to remove her right fallopian tube.
- Misdiagnosed a molar pregnancy — when tissue that normally becomes a fetus becomes an abnormal growth — and gave the patient the wrong drug for depletion of her red blood cells.

- Misdiagnosed polycystic ovarian disease in two patients and performed ovarian drilling, surgery that doesn't help the condition. The procedure can help with related infertility but should only be used after medications have been tried.
- Prescribed drugs that contributed to a patient's rebound headaches and dependency. In addition, Mondloch did a hysterectomy on the patient without first attempting non-surgical treatments. She also failed to properly manage bleeding during the hysterectomy.

The complaint doesn't say how the five patients fared. But Mondloch told the State Journal that, other than the patient whose fallopian tube was removed, the patients were pleased with the care she provided. Three of them remain her patients, she said.

The hysterectomy patient's bleeding was from a platelet disorder not identified until after the surgery, Mondloch said.

She said her care complies with American College of Obstetricians and Gynecologists guidelines.

The ban on Mondloch's obstetrics work, issued in January 2012, will continue until the board takes final action. She can still do routine exams, check-ups and tests such as Pap smears. She runs an independent clinic in Waukesha.

Dr. Sheldon Wasserman, chairman of the medical board, said the board ordered Mondloch to complete a mini-residency in 2004 and her mentors said she showed progress.

The obstetrics ban last year should further protect the public, said Wasserman, also an OB/GYN.

"OB/GYN is where she's dangerous," he said. "We're taking that away from her."

— *David Wahlberg wrote this series while participating in the California Endowment Health Journalism Fellowships, a program of USC's Annenberg School for Communication and Journalism.*

Doctor Discipline three-part special report

Today: Wisconsin rarely suspends or revokes medical licenses, leading some to question if the state does enough to ensure patient safety.

Monday: Even in cases where a jury gives the patient a large award, the state may not take any disciplinary action against the doctor.

Tuesday: Wisconsin Medical Board members say they'd like to be tougher on doctors but don't have the authority or money to do so.

Search for yourself

To check if any doctor has ever been disciplined by the medical board and read about those cases:

1. Go to go.madison.com/doctors.
2. Under profession, select medicine and surgery.
3. Enter a doctor's name and click search.
4. Click on the doctor's name.
5. Click on orders. If any appear, click to read them. If none appear, the doctor hasn't been disciplined.

Medical Board says lack of money, authority ties hands and may attract subpar physicians to state

DOCTOR DISCIPLINE: THIRD OF A THREE-PART SPECIAL INVESTIGATION



JANUARY 29, 2013 5:00 AM • DAVID WAHLBERG |
WISCONSIN STATE JOURNAL |
DWAHLBERG@MADISON.COM | 608-252-6125

After the Wisconsin Medical Examining Board suspended Dr. Frank Salvi in 2009 for fondling four female patients, the Madison-area doctor won a circuit court ruling throwing out the sanction.

Then, the medical board won an appeals court decision restoring it. Salvi failed to get the state Supreme Court to take the case.

But he succeeded in making the medical board spend about \$200,000 to fight him, said Dr. Sheldon Wasserman, board chairman.

The board, which has a \$1.9 million annual budget and gets about 500 complaints against doctors each year, can't afford to do that very often, Wasserman said.

"We're using up our resources fighting their resources," he said.

The budget for Wisconsin's medical board appears to be smaller than for boards in other states. It's one of several factors that limit the board, its leaders say.

The board has supported bills to remove other limitations, such as a lack of authority to launch investigations on its own or to perform criminal background checks on doctors applying for licenses.

But the state Legislature didn't pass the measures. "I think that would expand their authority too far," said state Sen. Leah Vukmir, R-Wauwatosa, chairwoman of the Senate Committee on Health and Human Services, who opposed both moves.

Other changes have been approved, such as requiring doctors to report wrongdoing by others. That started in 2009.

The board doesn't have independent authority. As part of the state Department of Safety and Professional Services, it works within departmental rules as well as state statutes and Supreme Court rulings, said Gene Musser, a board member and previous chairman.

The department, for example, hires and fires board staff.

Despite the limitations, the medical board and the department protect the public by ensuring that doctors provide safe and competent care, said Greg Gasper, the department's executive assistant. Reforms have led to a 36 percent reduction in pending cases over the past two years, Gasper said.

"Better management has resulted in more disciplinary action and reduced pending caseloads," he said.

Musser acknowledged that a major reason Wisconsin ranks low in serious discipline against doctors is the board's preference for reprimands instead of more serious penalties in many cases.

Even if the board had more money or more power, its frequent use of reprimands likely would continue because the board generally values rehabilitation over harsh discipline, he said.

"Our wings are clipped"

In 2009, amid criticism that the medical board took too long to discipline doctors, Wisconsin raised the biennial license fee for doctors from \$106 to \$141 — an amount still lower than in most states.

That paid for more investigators and increased the board's budget to \$1.8 million that year. This year, it's \$1.9 million.

But while the board had a team of 10.5 attorneys, paralegals and investigators in 2010, a reorganization reduced the team to 7.7 positions, officials said.

"Our wings are clipped again," Wasserman said.

The board's total staff is about 14 positions, department officials said, but some of those people also work for other boards.

Wasserman said the board's limited resources mean the board must be cautious in taking a hard line against doctors such as Salvi, who worked at UW Hospital until resigning in 2007.

The result is more plea bargaining for lesser forms of discipline, Wasserman said.

Salvi, of Cottage Grove, denied the charges against him. His license remains suspended and he is looking for work, said his attorney, Lester Pines. Salvi declined to comment.

More resources in other states

No state-by-state comparison of medical board budgets is available, but medical boards in some states are better funded than in Wisconsin.

The State Medical Board of Ohio has a \$9.1 million budget and the equivalent of 79 full-time staff. Though Ohio has twice as many doctors as Wisconsin, its medical board budget is nearly five times greater.

Ohio was among the top three states for serious discipline against doctors in Public Citizen reports the past two years.

The medical board in Ohio is a separate agency, not part of a state department, said Joan Wehrle, the board's outreach manager.

"It makes a huge difference," Wehrle said. "You set the priorities."

Ohio's board developed guidelines that suggest minimum and maximum penalties for various violations. Wisconsin's board has no such guidelines.

From 2009 to 2011, the Ohio board revoked the licenses of 118 doctors and issued 20 reprimands. Wisconsin's board issued five revocations and 115 reprimands during that time.

"If there's patient harm, the board will usually issue a stronger sanction than a reprimand," Wehrle said.

The State Journal contacted medical boards in four states with populations and doctor numbers similar to Wisconsin's.

Their budgets: Colorado, \$2.9 million; Minnesota, \$5.3 million; Missouri, \$2.6 million; and Tennessee, \$2 million.

Legislature says no

Wisconsin statutes say the medical board should investigate complaints of unprofessional conduct against doctors, but they don't say the board can look into suspected wrongdoing on its own.

A 2003 bill to change some medical board operations, including allowing proactive investigations, wasn't approved by the state Legislature. The Federation of State Medical Boards doesn't track how many states do such investigations.

Musser said proactive probes could lead to more discipline.

"I believe there are physicians around the state doing stuff they shouldn't be doing that we don't hear about because it doesn't get reported to us," he said.

Likewise, requiring background checks when doctors apply for licenses could identify more doctors with criminal pasts, Musser said.

Medical boards in 36 states require background checks, according to the Federation of State Medical Boards. The Wisconsin board's attempt to do so last year was overruled by the Legislature.

Rep. Erik Severson, R-Star Prairie, co-sponsored the bill that prevented the board from doing routine criminal background checks.

Severson, a doctor, said requiring fingerprints for the background checks would be costly.

"They'd be adding an extra burden on physicians who want to come here to Wisconsin at a time when we have a physician shortage," he said. "It seems like an overreach on government's part to solve a problem that doesn't exist."

But by not doing the checks, Wisconsin could eventually attract doctors with criminal records, Musser said.

"As more states do that, we may become sort of a magnet," he said.

The Legislature approved a "duty to report" requirement in 2009. Doctors must report other doctors who engage in unprofessional conduct or endanger patients.

Wasserman said the requirement has led to more complaints and discipline, though a board spokeswoman said no data are available on the impact of the requirement.

More changes

Last year, the board revised the state's administrative rule defining unprofessional conduct for doctors. The changes are subject to approval this year by the Legislature and the governor.

The board specified wrong-site surgery as unprofessional conduct, for example. It also listed specific crimes, such as sexual assault and child enticement. That should bring quicker action in such cases, Wasserman said.

But some proposed changes weren't adopted by the board, largely because they were opposed by the Wisconsin Medical Society and the Wisconsin Hospital Association.

One would have required doctors to tell patients about alternative diagnoses and treatments. Another would have made doctors tell the board about actions taken against their hospital privileges.

"That was a battle I could not win," said Wasserman, a former Democratic state Assembly member from Milwaukee.

Wasserman and Musser said they hope the board will make other changes. One is to require more continuing education when doctors renew their licenses every two years. Currently, 30 hours are required.

They also want doctors to complete three years of training after medical school before qualifying for a license in Wisconsin.

Most states require one year for graduates of U.S. medical schools but two or three years for graduates of foreign schools. Wisconsin requires one year for both.

"We are basically the dumping ground for a lot of bad physicians who want to get their foot in the American medical system," Wasserman said.

— *David Wahlberg wrote this series while participating in the California Endowment Health Journalism Fellowships, a program of USC's Annenberg School for Communication and Journalism.*

Doctor Discipline three-part special report

Sunday: Wisconsin rarely suspends or revokes medical licenses, leading some to question if the state does enough to ensure patient safety.

Monday: Even in cases where a jury gives the patient a large award, the state may not take any disciplinary action against the doctor.

Tuesday: Wisconsin Medical Board members say they'd like to be tougher on doctors but don't have the authority or money to do so.

State's online info lacking

Many states provide more information about doctors on their websites than Wisconsin does, according to the Federation of State Medical Boards.

In 18 states, online doctor profiles include malpractice findings, the federation says. In 16 states, criminal convictions are available. Hospital actions, such as a loss of privileges, are mentioned in 11 states.

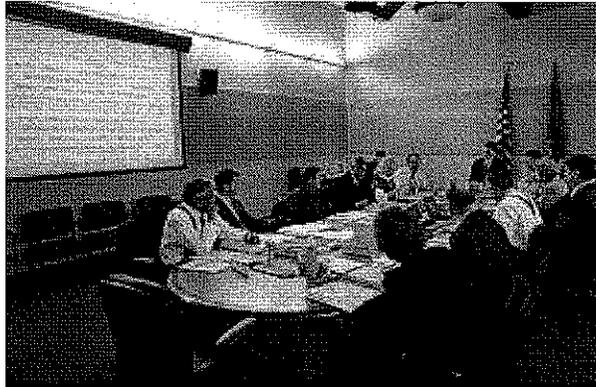
Wisconsin doesn't include any of those. The federation says all states should.

Search for yourself

To check if any doctor has ever been disciplined by the medical board and read about those cases:

1. Go to go.madison.com/doctors.
2. Under profession, select medicine and surgery.
3. Enter a doctor's name and click search.
4. Click on the doctor's name.
5. Click on orders. If any appear, click to read them. If none appear, the doctor hasn't been disciplined.

How the Wisconsin Medical Examining Board handles complaints about doctors



JANUARY 29, 2013 5:00 AM • DAVID WAHLBERG |
WISCONSIN STATE JOURNAL |
DWAHLBERG@MADISON.COM | 608-252-6125

The state Department of Safety and Professional Services receives about 500 complaints against Wisconsin doctors each year.

Half are from patients or family members. Some are from health care workers. Others are malpractice findings or hospital actions reported through a national data bank.

State investigators request medical records and ask doctors for a response.

A screening panel of the Wisconsin Medical Examining Board reviews cases each month. The panel closes about two-thirds of the cases, generally because the complaints are minor or can't be proven, said Dr. Gene Musser, a board member and former chairman.

For the other cases, formal investigations are launched. An investigator, attorney and lead board member gather more information and decide if the doctor should be disciplined and how. The full board has the final say.

Options are an administrative warning (which doesn't count as official discipline), required education, a reprimand, a license limitation, a suspension or a revocation. Many times a combination is used, such as a reprimand plus required education.

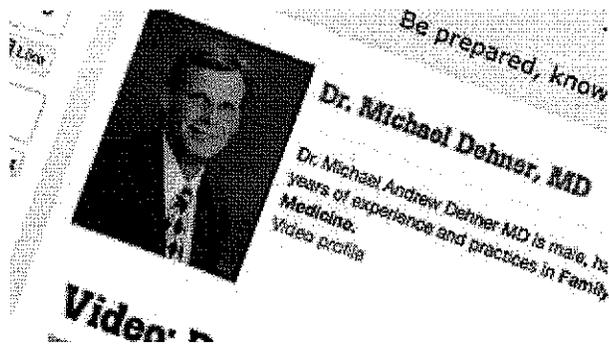
The board attorney generally negotiates with the doctor's attorney until they reach an agreement.

But sometimes doctors request a hearing before an administrative law judge. The judge recommends a type of discipline, which the board can adopt or not.

Doctors can appeal through the state court system.

Case study: Dr. Michael Dehner's career in state plagued by mistakes, lawsuit, deaths

CASE STUDY: DR. MICHAEL DEHNER



JANUARY 26, 2013 2:00 PM • DAVID WAHLBERG |
WISCONSIN STATE JOURNAL |
DWAHLBERG@MADISON.COM | 608-252-6125

Dr. Michael Dehner's career in Wisconsin started on a sour note in 1999, with a restricted license because of drug prescription problems.

It ended with a finding in 2011 that his medical knowledge was "superficial."

In between, a death, a stillbirth and a misdiagnosis led the Wisconsin Medical Examining Board to discipline Dehner three times for substandard care.

The board expressed concern about another death but took no action. It hasn't investigated an additional death settled out of court last year.

Dehner's time in Wisconsin shows how the board's authority to investigate in reaction to complaints, but not launch its own inquiries, can lead the board to clear doctors after one mishap without knowing other problems have occurred.

The board reprimanded Dehner and limited his practice but never suspended him. He worked in Boscobel before moving in late 2010 to Storm Lake, Iowa, where he worked at a community health center until October 2012.

He declined to comment to the State Journal.

"When you get disciplined, you get slapped on the hand and get to continue to practice," said attorney John Cates of Madison.

Cates sued on behalf of the family of 9-year-old Andrew Chase, of Fennimore, who died from diabetic ketoacidosis in 2008. The suit led to a confidential settlement last year.

Andrew slipped into a diabetic coma at the hospital in Boscobel, but Dehner didn't transfer him to UW Hospital until the next day, according to the lawsuit. The boy died two weeks later.

"It was pretty gross mismanagement," Cates said.

Malpractice settlements are supposed to generate complaints to the medical board, but a board spokeswoman said the board hasn't received a complaint in the Chase case; she couldn't explain why. Dehner's license in Wisconsin expired in October 2011.

Kent Nebel, legal affairs director of the Iowa Board of Medicine, said he couldn't say if that board has been notified of the case.

According to medical board documents:

- In 1999, the board issued Dehner's license, immediately restricting it because he had over-prescribed controlled substances to patients in Iowa. The Wisconsin board ordered Dehner to undergo drug screening four times a month. In 2001, it reduced the requirement to twice a month. In 2004, it removed all restrictions from his license.
- A week before the board reduced the drug screenings in 2001, Dehner failed to decompress the stomach of an 88-year-old woman with a bowel obstruction. He gave her a drug that could make her obstruction worse. She died the same day. The board reprimanded Dehner in 2006, fined him \$4,000 and required him to take a gastroenterology review course. Three months later, the board acknowledged he had taken the course.
- In 2006, two weeks after he took the course and a month before the board's acknowledgment, Dehner diagnosed a 94-year-old man with a viral gastrointestinal illness even though an X-ray showed a bowel obstruction, according to a radiologist.

The man died two weeks later. "Dehner is a problem," Dr. Suhatha Kailas, a board member investigating the incident, wrote in 2007.

"I think Dehner missed a small bowel obstruction. What worries me about him is the fact that he had just been disciplined for similar issues just a few months prior." But the board took no action in the new case, saying there was insufficient evidence of a violation.

- In 2008, the board restricted Dehner's license for a stillbirth and fined him \$12,548. The stillbirth happened in 2004, six weeks after the board removed all restrictions from his initial license. He failed to recognize placental abruption, when the placenta peels away from the wall of the uterus. He also gave the laboring mother two drugs too closely together and administered fentanyl, which can worsen fetal distress.

The board required Dehner to take obstetrics courses, be mentored by an obstetrician, have his obstetrics charts reviewed and refrain from deliveries unless another doctor was present.

- In 2010, the board investigated an incident from 2008 — which happened in the weeks just before the discipline for the stillbirth — in which Dehner repeatedly misdiagnosed a young woman's gallstones as constipation. She eventually went to a doctor in La Crosse who promptly removed her gallbladder and gallstones.

The board ordered Dehner to undergo an assessment at UW School of Medicine and Public Health. A report in 2011 found that he "demonstrated a number of deficiencies as a physician ... It was felt that (Dehner's) medical knowledge was superficial and lacking in detail."

- In 2012, in response to the missed gallstones, the board fined Dehner \$1,650 and required him to take classes in record keeping and family medicine, and have some

charts reviewed. The Iowa Board of Medicine followed up by placing Dehner on probation for five years. About the same time, he stopped working at the clinic in Storm Lake.

He is working as a fill-in emergency medicine doctor, though it's not clear where, said Brad Meyer, who runs the Storm Lake clinic. Nebel said the Iowa board doesn't know where Dehner is working.

Other cases where patients were seriously harmed but doctors were only reprimanded

JANUARY 26, 2013 2:00 PM • DAVID WAHLBERG | WISCONSIN STATE JOURNAL |
DWAHLBERG@MADISON.COM | 608-252-6125

Here are summaries of five other cases in which patients died or were seriously harmed and their doctors received reprimands from 2010 to 2012, based on court and Wisconsin Medical Examining Board records:

Sherry Bartz, of Edgerton, died in 2008 at age 58 from blood clots in her lung after battling an infection in her abdomen from hernia surgery a month earlier. **Dr. Mark McDade** did the surgery at Mercy Hospital in Janesville.

Bartz had a sinus infection before the elective surgery, so McDade should have postponed the procedure, the medical board said. In addition, McDade didn't properly treat Bartz's post-surgery infection, the board said.

A lawsuit by Jeff Bartz, Sherry's husband, led to a confidential settlement in 2011. McDade declined to comment.

Last year, the board reprimanded McDade, who works at Dean Clinic in Janesville, and fined him \$2,050. He had already attended a conference on abdominal wall surgeries.

Laron Birmingham was born at St. Joseph Regional Medical Center in Milwaukee in 2005 with cerebral palsy and other neurological problems. **Dr. Donald Baccus** used two kinds of forceps and a vacuum in the delivery. In 2010, a jury found negligence and awarded the family \$23.3 million.

Baccus should have done a cesarean section, the medical board said. The board reprimanded him in 2012 and fined him \$3,850. He had already stopped doing obstetrics and retired in June.

Baccus told the State Journal he delivered about 5,000 babies over 25 years and was sued only two other times; both of those cases were dismissed early on.

He noted that defense witnesses said the problems with Laron Birmingham's brain were not the result of Baccus' actions.

Cara and Vince Dreyer's first baby was stillborn in 2008 at Westfields Hospital in New Richmond. **Dr. Susan Frazier** misread the fetal monitoring strip, leading to a delayed cesarean section delivery, the medical board said.

The Dreyers' lawsuit against Frazier led to a confidential settlement in 2011. The board reprimanded Frazier in 2012 and fined her \$275. She now works in Rib Lake, northwest of Wausau.

She told the board she stopped doing obstetrics. She declined to comment, other than to confirm that she isn't delivering babies.

Elizabeth Ferris, of Marshfield, was 37 weeks pregnant with her third child when she went to the emergency room at St. Joseph's Hospital in Marshfield at 4:40 a.m. one day in 2005. She was worried her fetus wasn't moving enough.

Fetal heart monitoring suggested distress, but **Dr. Katherine Kaplan** discharged Ferris at 6:30 a.m. She told her to return for her scheduled appointment with her regular doctor at 10 a.m.

At that appointment, an ultrasound showed the fetus had died. Ferris' lawsuit against Kaplan, who still is with Marshfield Clinic, led to a confidential settlement in 2009. Kaplan declined to comment.

The medical board reprimanded Kaplan in 2011 and fined her \$1,000. She had already taken fetal monitoring courses ordered by North Carolina's medical board.

Patricia Jungwirth, of Oshkosh, died from a bowel obstruction in 2008, five days after pelvic reconstruction surgery. The day before she died, she saw **Dr. Megan Landauer** for a bloated stomach at Aurora Medical Center in Oshkosh.

"I see no reason to think she has a bowel obstruction," Landauer wrote.

Landauer told Jungwirth to take milk of magnesia and come back the next day. She should have considered Jungwirth's symptoms to be a potential emergency, the medical board said. A lawsuit led to a confidential settlement in 2010.

The board reprimanded Landauer in 2011 and fined her \$958. She had already taken 50 hours of continuing education.

Landauer, who declined to comment, now works at Marshfield Clinic in Minocqua and Park Falls.

Five doctors lost licenses over crimes, drugs

JANUARY 26, 2013 2:00 PM • DAVID WAHLBERG | WISCONSIN STATE JOURNAL |
DWAHLBERG@MADISON.COM | 608-252-6125

Murder, child pornography and improper prescribing of pain medications are among the reasons the Wisconsin Medical Examining Board revoked the licenses of five doctors from 2010 to 2012.

None of the doctors could be reached for comment. Summaries of their cases, according to board documents:

- **Gerhard Witte, 2010:** Witte, of Milwaukee, was convicted of first-degree intentional homicide in 2010 for killing his former wife, a musician with the Milwaukee Symphony Chorus. He stabbed her and slit her throat in 2008 as she walked to her car after a performance. Witte, who practiced internal medicine, was sentenced to life in prison without parole.
- **Eric Schwietering, 2011:** Schwietering, of Milwaukee, pleaded guilty to two counts of possession of child pornography in 2007. Three years later, the child psychiatrist was convicted of fourth degree sexual assault and exposing his genitals to a child. He now lives in Ohio, according to Wisconsin's sex offender registry.
- **William Braunstein, 2011:** Braunstein, of St. Louis Park, Minn., told the state of Minnesota that he had depression and possible attention deficit disorder and obsessive compulsive disorder. After the internal medicine doctor failed to attend therapy sessions and cooperate with the Minnesota Board of Medical Practice, that board threatened to suspend his license. That prompted the Wisconsin medical board to investigate. After he failed to cooperate, the board revoked his Wisconsin license. Then the Minnesota board suspended his license there.
- **Steven Greenman, 2011:** Greenman, of Milwaukee, prescribed controlled substances "indiscriminately" to six patients over five years, despite signs of drug abuse, addiction and diversion. He also directed the patients to multiple pharmacies. When one patient called him prior to reporting to jail, she asked for more pain medications as a "last hurrah" and he complied.
- **Mark Fantauzzi, 2012:** Fantauzzi, of Circleville, Ohio, had his license revoked by the State Medical Board of Ohio after surrendering his controlled substances privileges with the federal Drug Enforcement Administration. The DEA said the anesthesiologist prescribed controlled substances outside of the usual course of professional practice, causing a patient's fatal overdose. The Wisconsin board followed up on the Ohio board's action.

Medical Examining Board lacks backbone, funding

JANUARY 30, 2013 5:00 AM • WISCONSIN STATE JOURNAL EDITORIAL

We all make mistakes.

But when doctors mess up, the consequences can maim and kill.

That's why doctors require so much education and earn so much respect and money.

It's also why doctors must be held accountable — especially for flagrant and repeated errors — to protect the public from further harm.

The Wisconsin Medical Examining Board needs to do a better job of disciplining the worst doctors. The State Journal's three-day series this week, "Doctor Discipline," made that painfully clear.

The board needs to show more backbone. And the Legislature needs to stop raiding the doctor fees that are supposed to fund the board's vital oversight of medical professionals.

The State Journal investigation by medical reporter David Wahlberg found that most doctors disciplined by the state medical board in recent years received reprimands, which are warnings that go on their records but don't limit their practices. That's true even in many of the cases where patients died or were harmed.

As a result, the state ranks near the bottom nationally for the strength of its disciplinary actions.

Consider, for example, just one of the many (and simplest) example's in the newspaper series: The Wisconsin doctor who operated on the left side of a woman's spine instead of on the right side where he was supposed to. That same doctor did the same thing a year later to another patient — only to receive a reprimand from the board (with a token fine of \$2,500, based on investigation costs, and a two-day patient safety workshop).

Repeatedly screwing up in such a profound way in such a short span of time demands a stiffer penalty than that, such as a license suspension. A reprimand should be used for lesser cases of poor judgment, such as the doctors who wrote bogus sick notes to protesters at the state Capitol in 2011.

Yes, badly harmed patients often settle out of court for undisclosed amounts of money. But the issue here is whether the state suspends or revokes doctors' licenses to deter future harm.

Too often, the state medical board is settling for slaps on the wrist. That needs to change, with more aggressive actions, better funding and authority.

Hands on Wisconsin: Slap on the wrist



JANUARY 30, 2013 5:00 AM • PHIL HANDS | WISCONSIN STATE JOURNAL | PHANDS@MADISON.COM

The recent Wisconsin State Journal investigation on disciplining doctors was eye-opening. Our Medical Examining Board rarely cracks down on doctors who make mistakes. Often the board lacks the funding and man-power to conduct thorough investigations that would lead to more than reprimands for doctors who through carelessness or simple poor judgment dramatically damage their patients.

That needs to change. Doctors have a great responsibility to keep their patients safe, and those who mess up, should face serious consequences. Those who repeatedly mess up should lose their licenses.

I doubt Wisconsin has doctors as incompetent as *The Simpsons* character, Dr. Nick Riviera, who is depicted in this cartoon. The vast majority of Wisconsin's physicians are professional life-savers. They deserve our respect and our praise.

Mistakes in the medical profession are rare, because most doctors are exceptionally careful and safe practitioners. But when mistakes are made the results can be dire. The consequences for those mistakes should also be.

Phil Hands



Phil Hands blogs about his funny and fierce political cartoons for the State Journal. In his spare time, Hands enjoys eating cheese, drinking coffee and being cold.

Video: See how Hands creates a cartoon

Follow @PhilHands

Follow 6

Skip Virchow: How can board dismiss patient's pain, costs?

JANUARY 30, 2013 4:00 AM

In the series on doctor discipline, an interesting comment was made by Dr. Gene Musser of the Wisconsin Medical Examining Board about the criteria used by the board as compared to criteria used by a civil court.

He said that in court, lawyers must show negligence caused damage with financial implications. But in the medical review they only have to prove the action created a danger to the patient and that's it. He stated: "The outcome is irrelevant."

The medical review board appears to ignore the financial implications the negligence has caused to the patient.

I cannot comprehend that, when a person who has suffered from negligence at the hands of a doctor and will spend the rest of his life suffering both physical and financial problems, it's of no consequence to the board.

— *Skip Virchow, Marshall*



Marla Maeder: Medical board case of fox guarding henhouse

FEBRUARY 01, 2013 4:00 AM

Thanks for your excellent series on doctor discipline. Our state's Medical Examining Board, made up of 13 governor-appointed members, including 10 doctors, appears to be a case of the fox guarding the hen house and the medical lobby ruling the roost.

The board's toothless reprimands for serious, sometimes fatal, mistakes are shocking.

We pay a high price for health care in this country. Wisconsin's doctor oversight board should do a better job of making sure we don't pay with our lives.

- *Marla Maeder, Madison*

Dr. Nicholas Hartog: Simplistic to blame just doctor, not medical team

FEBRUARY 01, 2013 4:00 AM

Doctors are part of and often the leader of the medical team. However, when a mistake happens, the whole team and the system made an error, not any particular individual.

It is important to remember everyone involved in the medical system is human. In this regard, it is correct for the state medical board to focus on education and quality improvement rather than punishment.

When a medical mistake happens, it is imperative to do a root cause analysis, in which individuals from different specialties study the course of events to determine what happened. Medical errors are the result of smaller mistakes, oversights, and/or systems errors. Rarely can a mistake be pinned on one person or one system error.

While doctors are an integral part of the multidisciplinary team that cares for patients, to imply they are the sole reason for medical errors is a simplistic and arrogant view.

- Dr. Nicholas Hartog, University of Iowa Hospitals and Clinics

**THE STATE MEDICAL BOARD OF OHIO
DISCIPLINARY GUIDELINES**

(Revised December 2011)

Disciplinary Guidelines are primarily for the Board's reference and guidance. They are subject to revision at the Board's discretion without notice to the public. Disciplinary Guidelines are intended to promote consistency in Board-imposed sanctions, but are not binding on the Board. The Board recognizes that individual matters present unique sets of circumstances which merit individual consideration by the Board.

CATEGORIES OF VIOLATIONS

Category	Title	Page
Category I	Improper Prescribing, Dispensing, or Administering of Drugs	3
Category II	Minimal Standards of Care	7
Category III	Fraud, Misrepresentation, or Deception	8
Category IV	Ethics Violations	10
Category V	Actions by Other States or Entities	11
Category VI	Unauthorized Practice	12
Category VII	Violation of Conditions of Limitation	15
Category VIII	Criminal Acts or Convictions	16
Category IX	Impairment of Ability to Practice	19
Category X	CME	23
Category XI	Miscellaneous Violations	25

APPENDICES

Appendix	Title	Page
Appendix A	Applicability of Guidelines to Licensure and Training Certificate Applicants	26
Appendix B	Aggravating and Mitigating Factors	27

**CATEGORY I: IMPROPER PRESCRIBING, DISPENSING, OR ADMINISTERING
OF DRUGS**

- A. Prescribing, dispensing, or administering of any drug for excessive periods of time and/or in excessive amounts.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Definite suspension, min. 90 days; subsequent probation, min. 2 years, to include prescribing course

- B. (Reserved)

- C. (Reserved)

- D. Failing to keep patient records of substances prescribed, dispensed or administered; and/or failing to perform appropriate prior examination and/or failure to document in the patient record performance of appropriate prior examination.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Reprimand; probation, min. 2 years, to include medical-recordkeeping course

- E. (Reserved)

- F. Inappropriate purchasing, controlling, dispensing, and/or administering of any drug.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Definite suspension, min. 60 days; subsequent probation, min. 2 years

G. Failure to use acceptable methods in selection of drugs or other modalities.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 180 days, with conditions for reinstatement; subsequent probation, min. 3 years

H. (Reserved)

I. Selling, prescribing, dispensing, giving away, or administering any drug for other than a legal and legitimate therapeutic purpose and/or selling, prescribing, dispensing, giving away, or administering any drug in exchange for sexual favors.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Permanent revocation of certificate or permanent denial of application

J. (Reserved)

K. (Reserved)

L. Plea of guilty to, judicial finding of guilt of, or judicial finding of eligibility for intervention in lieu of conviction for, a drug related felony, except where the underlying criminal conduct was directly related to a substance-related impairment of the respondent and was committed to obtain substance(s) solely for self-use.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Permanent revocation of certificate or permanent denial of application

- M. Plea of guilty to, judicial finding of guilt of, or judicial finding of eligibility for intervention in lieu of conviction for, a drug-related misdemeanor, except where the underlying criminal conduct was directly related to a substance-related impairment of the respondent and was committed to obtain substance(s) solely for self-use.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application.

Minimum Penalty: Indefinite suspension, min. 180 days, with conditions for reinstatement; subsequent probation, min. 2 years.

- N. Plea of guilty to, judicial finding of guilt of, or judicial finding of eligibility for intervention in lieu of conviction for, a drug related felony where the underlying criminal conduct was directly related to a substance-related impairment of the respondent and was committed to obtain substance(s) solely for self-use.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application.

Minimum Penalty: 90 days of suspension in addition to the minimum penalty for the applicable guideline section under Category IX.

- O. Plea of guilty to, judicial finding of guilt of, or judicial finding of eligibility for intervention in lieu of conviction for, a drug-related misdemeanor where the underlying criminal conduct was directly related to a substance-related impairment of the respondent and was committed to obtain substance(s) solely for self-use.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application.

Minimum Penalty: 30 days of suspension in addition to the minimum penalty for the applicable guideline section under Category IX.

- P. Utilizing a controlled substance in the treatment of a family member or self in violation of Section 4731-11-08, Ohio Administrative Code.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Reprimand; probation, min. 2 years, to include appropriate medical-education course

Review/Revision History:

Sections I.M, I.O, and I.P: 12/10

Sections I.A through I.K: 10/10

Sections I.L and I.N: 7/10

CATEGORY II: MINIMAL STANDARDS OF CARE

A. Departure from or failure to conform to minimal standards of care.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Probation, min. 3 years

B. Sexual misconduct within practice.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 1 year, with conditions for reinstatement;
subsequent probation as appropriate

**NOTE: WHERE APPROPRIATE, PERMANENT LIMITATIONS AND RESTRICTIONS
MAY ALSO BE IMPOSED.**

Review/Revision History:

Sections II.A and II.B: 1/11

CATEGORY III: FRAUD, MISREPRESENTATION, OR DECEPTION

A. Fraud in passing examination.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Revocation of certificate or denial of application (minimum required by statute)

B. (Reserved)

C. (Reserved)

D. Publishing a false, fraudulent, deceptive, or misleading statement.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Suspension for 30 days; subsequent probation, min. 1 year

E. (Reserved)

F. Obtaining, or attempting to obtain, anything of value by fraudulent misrepresentations in the course of practice.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 1 year, with conditions for reinstatement; subsequent probation, min. 2 years

G. Deceptive advertising.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Suspension for 30 days; subsequent probation, min. 1 year

- H. Representing, with purpose of obtaining compensation or advantage, that incurable disease can be cured.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 3 years, with conditions for reinstatement to include SPEX and personal/professional ethics courses; subsequent probation, min. 5 years, including requirements for a practice plan and monitoring physician prior to resuming practice

NOTE: SEE APPENDIX A IF VIOLATION BY LICENSURE APPLICANT.

Review/Revision History:

Sections III.A through III.H: 2/11

CATEGORY IV: ETHICS VIOLATIONS

- A. Division of fees for referral of patients, or receiving a thing of value for specific referral of patient to utilize particular service or business.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 1 year, with conditions for reinstatement; subsequent probation as appropriate

- B. Code of ethics violation.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Reprimand

- C. Willfully betraying a professional confidence.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Suspension for 30 days; subsequent probation, min. 1 year, to include condition of successfully completing appropriate ethics course(s)

NOTE: SEE CATEGORY II PENALTIES FOR SEXUAL MISCONDUCT WITHIN PRACTICE, AND CATEGORY III PENALTIES FOR FRAUDULENT ACTS.

Review/Revision History:

Sections IV.A through IV.C: 5/11

CATEGORY V: ACTIONS BY OTHER STATES OR ENTITIES

Limitation, revocation, suspension, acceptance of license surrender, denial of license, refusal to renew or reinstate a license, imposition of probation, or censure or other reprimand, by another jurisdiction; action against clinical privileges by Department of Defense or Veterans Administration; or termination or suspension from Medicare or Medicaid.

Maximum Penalty: Correspond to maximum penalty in Ohio for type of violation committed

Minimum Penalty: Correspond to minimum penalty in Ohio for type of violation committed

Review/Revision History:

Category V: 5/11

CATEGORY VI: UNAUTHORIZED PRACTICE

- A. Practice during suspension imposed by Board order.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Permanent revocation of certificate or permanent denial of application

- B. Applicant's prior practice without license or registration as physician assistant, anesthesiologist assistant, or radiologist assistant.

Maximum Penalty: Denial of licensure or P.A./A.A./R.A. registration with conditions for any future application

Minimum Penalty: Denial of licensure or P.A./A.A./R.A. registration

- C. Aiding and abetting unlicensed practice or practice by unregistered physician assistant, anesthesiologist assistant, or radiologist assistant.

Maximum Penalty: One-year suspension; subsequent 2-year probation including requirement of annual report of utilization of employee or P.A./A.A./R.A.

Minimum Penalty: Suspension for 30 days; subsequent 2-year probation including requirement of annual report of utilization of employee or P.A./A.A./R.A.

- D. Practice outside scope of license or registration.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: 30-day suspension

- E. Supervising a physician assistant, anesthesiologist assistant, or radiologist assistant in the absence of an approved supervisory plan and approved supervision agreement.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Suspension for 90 days

- F. Practice of a physician assistant, anesthesiologist assistant, or radiologist assistant in the absence of an approved supervisory plan and an approved supervision agreement.
- Maximum Penalty: Permanent revocation of certificate or permanent denial of application
- Minimum Penalty: Suspension for 90 days
- G. Permitting a physician assistant, anesthesiologist assistant, or radiologist assistant to perform services as a P.A., A.A., or R.A. in a manner that is inconsistent with the supervisory plan or special services plan under which that P.A./A.A./R.A. practices.
- Maximum Penalty: Permanent revocation of certificate or permanent denial of application
- Minimum Penalty: Probation (non-appearing), min. 1 year
- H. Practice of a physician assistant, anesthesiologist assistant, or radiologist assistant in a manner that is inconsistent with the supervisory plan or special services plan under which that P.A./A.A./R.A. practices.
- Maximum Penalty: Permanent revocation of certificate or permanent denial of application
- Minimum Penalty: Probation (non-appearing), min. 1 year
- I. Permitting a physician assistant to perform services as a physician assistant in a manner that is not in accordance with Chapter 4730 or other applicable chapter of the Revised Code and/or the rules adopted thereunder.
- Maximum Penalty: Permanent revocation of certificate or permanent denial of application
- Minimum Penalty: Indefinite suspension, min. 180 days, with conditions for reinstatement; subsequent probation, min. 3 years
- J. Practice of a physician assistant in a manner that is not in accordance with Chapter 4730 or other applicable chapter of the Revised Code and/or the rules adopted thereunder.
- Maximum Penalty: Permanent revocation of certificate or permanent denial of application
- Minimum Penalty: Indefinite suspension, min. 180 days, with conditions for reinstatement; subsequent probation, min. 3 years

- K. Failure to timely report termination of a physician assistant supervision agreement to the Board.

Maximum Penalty: Suspension for 2 years

Minimum Penalty: Reprimand

- L. Limited Practitioner Holding Self Out as Doctor or Physician in Violation of Rule 4731-1-03(D) and/or 4731-1-03(E), Ohio Admin. Code.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 180 days; conditions for reinstatement to include eliminating the offending references from any advertising, internet sites, signs, business cards, stationery, and similar locations; subsequent probation, min. 2 years

**NOTE: SEE CATEGORY VII PENALTIES FOR PRACTICE IN VIOLATION OF
CONDITIONS OF LIMITATION PLACED BY THE BOARD**

Review/Revision History:

Sections VI.A through VI.K: 5/11

Section VI.L: 12/11

CATEGORY VII: VIOLATION OF CONDITIONS OF LIMITATION

- A. Violation of practice or prescribing limitations placed by the Board.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. one year, with conditions for reinstatement; subsequent probation, min. 3 years

- B. Violation of conditions of limitation, other than practice prohibitions, placed by the Board.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. as appropriate, with conditions for reinstatement; subsequent probation, min. 3 years

Review/Revision History:

Sections VII.A and VII.B: 8/11

CATEGORY VIII: CRIMINAL ACTS OR CONVICTIONS

- A. Plea of guilty to, judicial finding of guilt of, or judicial finding of eligibility for intervention in lieu of conviction for, a felony committed in course of practice, except where the underlying criminal conduct was directly related to a substance-related impairment of the respondent and was committed to obtain substance(s) solely for self-use.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Permanent revocation of certificate or permanent denial of application

- B. Plea of guilty to, judicial finding of guilt of, or judicial finding of eligibility for intervention in lieu of conviction for, a felony not committed in course of practice.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 30 days, with conditions for reinstatement; subsequent 3 year probation

- C. Commission of act constituting a felony in this state, regardless of where committed, if related to practice, except where the underlying criminal conduct was directly related to a substance-related impairment of the respondent and was committed to obtain substance(s) solely for self-use.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Permanent revocation of certificate or permanent denial of application

- D. Commission of act constituting a felony in this state, regardless of where committed, if unrelated to practice.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 30 days, with conditions for reinstatement; subsequent 3 year probation

- E. Plea of guilty to, judicial finding of guilt of, or judicial finding of eligibility for intervention in lieu of conviction for, a misdemeanor committed in course of practice or involving moral turpitude.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 180 days, with conditions for reinstatement; subsequent probation, min. 2 years

- F. Commission of act constituting a misdemeanor committed in course of practice or involving moral turpitude.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Suspension for 30 days; subsequent probation, min. 2 years

- G. Plea of guilty to, judicial finding of guilt of, or judicial finding of eligibility for intervention in lieu of conviction for, a felony committed in course of practice, where the underlying criminal conduct was directly related to a substance-related impairment of the respondent and was committed to obtain substance(s) solely for self-use.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application.

Minimum Penalty: 90 days of suspension in addition to the minimum penalty for the applicable guideline section under Category IX.

- H. Commission of act constituting a felony in this state, regardless of where committed, if related to practice, where the underlying criminal conduct was directly related to a substance-related impairment of the respondent and was committed to obtain substance(s) solely for self-use.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application.

Minimum Penalty: 90 days of suspension in addition to the minimum penalty for the applicable guideline section under Category IX.

NOTE: SEE CATEGORY I PENALTIES FOR DRUG RELATED CONVICTIONS

Review/Revision History:

Sections VIII.B and VIII.D: 8/11

Sections VIII.E and VIII.F: 9/10

Sections VIII.A, VIII.C, VIII.G, and VIII.H: 7/10

CATEGORY IX: IMPAIRMENT OF ABILITY TO PRACTICE

- A. Initial Impairment and/or Less than One Year of Sobriety: Impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances (including the inability to practice in accordance with such standards without appropriate treatment, monitoring, or supervision).

This section applies to:

- (1) All licensees holding an active certificate,
- (2) All licensees holding a previously active certificate that is currently expired/inactive/lapsed for any reason,
- (3) All applicants for licensure/reinstatement/restoration who have not demonstrated continuous current sobriety for at least one year since the date of the applicant's discharge from treatment where the treatment was completed and conformed with board requirements.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, no minimum, with conditions for reinstatement; subsequent probation, minimum 5 years

- B. "Slip Rule": Impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances (including the inability to practice in accordance with such standards without appropriate treatment, monitoring, or supervision), where all conditions set forth in Rule 4731-16-02(D), Ohio Administrative Code, have been met.

The Respondent will not be subjected to suspension or other formal discipline

- C. First Relapse: Impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances (including the inability to practice in accordance with such standards without appropriate treatment, monitoring, or supervision); first relapse during or following treatment, and/or where all conditions set forth in Rule 4731-16-02(D), Ohio Administrative Code, have not been met.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 90 days following date of license suspension (mandated by administrative rule), with conditions for reinstatement; subsequent probation, min. 5 years

- D. Second Relapse: Impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances (including the inability to practice in accordance with such standards without appropriate treatment, monitoring, or supervision); second relapse during or following treatment.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 1 year following date of license suspension (mandated by administrative rule), with conditions for reinstatement; subsequent probation, min. 5 years

- E. Third Relapse: Impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances (including the inability to practice in accordance with such standards without appropriate treatment, monitoring, or supervision); third relapse during or following treatment.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Indefinite suspension, min. 3 years following date of license suspension (mandated by administrative rule), with conditions for reinstatement; subsequent probation, min. 5 years

- F. Impairment, 1 - 5 Years of Sobriety: Impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances (including the inability to practice in accordance with such standards without appropriate treatment, monitoring, or supervision).

This section applies to all applicants for licensure/reinstatement/restoration who have demonstrated continuous current sobriety for more than one year, but less than five years, since the date of the applicant's discharge from treatment where the treatment was completed and conformed with board requirements.

Maximum Penalty: Permanent denial of application

Minimum Penalty: Application granted; subject to probation for a minimum term that, when added to the applicant's demonstrated period of continuous current sobriety, shall not be less than 5 years

- G. Impairment, 5+ Years of Sobriety: Impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances (including the inability to practice in accordance with such standards without appropriate treatment, monitoring, or supervision).

This section applies to all applicants for licensure/reinstatement/restoration who have demonstrated continuous current sobriety for more than five years since the date of the applicant's discharge from treatment where the treatment was completed and conformed with board requirements.

Maximum Penalty: Permanent denial of application

Minimum Penalty: License may be granted/reinstated/restored without probation or other disciplinary action

- H. Mental/Physical Illness, Currently Unable To Practice: Inability to practice according to acceptable and prevailing standards of care by reason of mental or physical illness (including any mental disorder, mental illness, physical illness, or physical deterioration that adversely affects cognitive, motor, or perceptive skills).

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: If applicant: Granting of license subject to indefinite suspension, min. as appropriate; conditions for reinstatement; subsequent probation, min. 2 years
If licensee: Indefinite suspension, min. as appropriate; conditions for reinstatement; subsequent probation, min. 2 years

- I. Mental/Physical Illness, Currently Able To Practice Subject To Appropriate Treatment, Monitoring, Or Supervision: Inability to practice according to acceptable and prevailing standards of care by reason of mental or physical illness (including any mental disorder, mental illness, physical illness, or physical deterioration, that adversely affects cognitive, motor, or perceptive skills) without appropriate treatment, monitoring, or supervision.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: If applicant: Granting of license subject to probationary terms and conditions, min. 2 years
If licensee: Probation, min. 2 years

Review/Revision History:

Sections IX.A through IX.I: 9/11

CATEGORY X: C.M.E. REQUIREMENTS

- A. Failure to respond timely to C.M.E. audit, but requisite C.M.E. completed.

Maximum Penalty: Reprimand; subject to mandatory audits of compliance with CME requirements for the current CME acquisition period and for two full CME acquisition periods thereafter.

Minimum Penalty: Reprimand.

- B. Failure to complete C.M.E. as certified on renewal application.

Maximum Penalty: Reprimand; \$5,000.00 fine; indefinite suspension until any outstanding shortage of CME credits has been rectified; subject to mandatory audits of compliance with CME requirements during suspension (if any), for the current CME acquisition period at the time of reinstatement (or for current CME acquisition period if no suspension), and for two full CME acquisition periods thereafter.

Minimum Penalty: Reprimand; \$1,000.00 fine; indefinite suspension until any outstanding shortage of CME credits has been rectified; subject to mandatory audits of compliance with CME requirements during suspension (if any), for the current CME acquisition period at the time of reinstatement (or for current CME acquisition period if no suspension), and for two full CME acquisition periods thereafter.

- C. Failure to complete C.M.E. as certified on renewal application; repeat offense.

Maximum Penalty: \$5,000.00 fine; indefinite suspension, min. 90 days, with conditions for reinstatement; subject to mandatory audits of compliance with CME requirements during suspension, for the current CME acquisition period at the time of reinstatement, and for two full CME acquisition periods thereafter.

Minimum Penalty: \$3,000.00 fine; indefinite suspension, min. 60 days, with conditions for reinstatement; subject to mandatory audits of compliance with CME requirements during suspension, for the current CME acquisition period at the time of reinstatement, and for two full CME acquisition periods thereafter.

NOTE: IF FRAUDULENT MISREPRESENTATIONS (OTHER THAN FALSE CERTIFICATION OF COMPLETION) ARE MADE WITH RESPECT TO C.M.E., CATEGORY III PENALTY MAY BE APPROPRIATE IN ADDITION TO THE STANDARD C.M.E. PENALTY. A BIFURCATED ORDER MAY BE USED.

Review/Revision History:

Sections X.A through X.C: 10/11

CATEGORY XI: MISCELLANEOUS VIOLATIONS

- A. Violating or attempting to violate, directly or indirectly, or assisting in or abetting violation of, or conspiring to violate, the Medical Practices Act or any rule promulgated by the Board.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Correspond to minimum penalty for actual offense

- B. Violation of any abortion law or rule.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Reprimand

- C. Permitting name or certificate to be used when not actually directing treatment.

Maximum Penalty: Permanent revocation of certificate or permanent denial of application

Minimum Penalty: Suspension, 1 year; subsequent probation, min. 1 year

- D. Failure to cooperate in an investigation conducted by the Board.

Maximum Penalty: Indefinite suspension of license with conditions for reinstatement to include, at a minimum, full cooperation in the underlying investigation.

Minimum Penalty: Reprimand, as long as respondent has fully cooperated in the underlying investigation.

Review/Revision History:

Sections XI.A through XI.D: 10/11

**APPENDIX A: APPLICABILITY OF GUIDELINES TO LICENSURE AND
TRAINING CERTIFICATE APPLICANTS**

The penalties specified in Categories I through XI are generally tailored to apply to violations of the Medical Practices Act by licensees. When applicants for licensure or training certificates are found to have committed like violations, the appropriate penalties will be formulated in terms of either grant, denial, or permanent denial of the application. A grant of a license or training certificate may be accompanied by limitation, suspension, requirements for reinstatement, probation, and/or reprimand, as appropriate, and should be proportionate to penalties imposed for licensees.

Review/Revision History:

11/11

APPENDIX B: AGGRAVATING AND MITIGATING FACTORS

After a violation has been established, the Board may consider aggravating and mitigating circumstances in deciding what penalty to impose. If the Board deems such circumstances sufficient to justify a departure from disciplinary guidelines, they should be specified during the Board's deliberations.

AGGRAVATION

Aggravation or aggravating circumstances are any considerations or factors which might justify an increase in the degree of discipline to be imposed. Aggravating factors may include, but are not limited to:

- (a) Prior disciplinary actions
- (b) Dishonest or selfish motive
- (c) A pattern of misconduct
- (d) Multiple violations
- (e) Submission of false evidence, false statements, or other deceptive practices during the disciplinary process
- (f) Refusal to acknowledge wrongful nature of conduct
- (g) Adverse impact of misconduct on others
- (h) Vulnerability of victim
- (i) Willful or reckless misconduct
- (j) Use/abuse of position of trust, or of licensee status, to accomplish the deception, theft, boundaries violation, or other misconduct
- (k) Where an individual has a duty to disclose information to the Board, the extent of delay in disclosing all or part of the information, including the failure to self-report relapse immediately to the Board as required
- (l) Failure to correct misconduct after recognizing the existence of the problem/violation

MITIGATION

Mitigation or mitigating circumstances are any considerations or factors which might justify a reduction in the degree of discipline to be imposed. Mitigating factors may include, but are not limited to:

- (a) Absence of a prior disciplinary record
- (b) Absence of a dishonest or selfish motive
- (c) Isolated incident, unlikely to recur
- (d) Full and free disclosure to Board, when done in a timely manner (such as before discovery is imminent)

- (e) Physical or mental disability or impairment
(NOTE: IT IS THE BOARD'S STATED POLICY THAT IMPAIRMENT SHALL NOT EXCUSE ACTS WHICH RESULT IN CONVICTION OR WHICH POTENTIALLY HAVE AN ADVERSE IMPACT ON OTHER INDIVIDUALS.)
- (f) Interim rehabilitation or remedial measures
- (g) Remorse
- (h) Absence of adverse impact of misconduct on others
- (i) Remoteness of misconduct, to the extent that the passage of time between the misconduct and the Board's determination of the sanction is not attributable to the respondent's delay, evasion, or other acts/omissions
- (j) Absence of willful or reckless misconduct
- (k) Prompt correction of misconduct/problem after recognizing its existence.

Review/Revision History:

11/11

requirements in the *International Fire Code*[®], and if so, the Comm 10 requirements would override those referenced requirements.

In reference to the 2009 changes to the definitions in IBC chapter 9, Jim noted those changes could have impacts on other parts of the code that are not yet fully considered at the national level, such as the expansion of “fire area” to better match the definition of “building area” in IBC chapter 5. Jim explained that if 2012 changes to the IBC are developed to address such impacts, the Department may include those changes in adopting the 2009 IBC.

In reference to the 2009 changes for fire areas in sections 903.2.9 and 903.2.9.1, Chris indicated some owners or designers may believe the allowed unsprinklered areas are too small.

Jim explained that the 2009 changes for balconies and decks in sections 903.2.9 and 903.2.9.1 clarify that fire sprinklers are not required where there is no overlying roof to trap heat.

Jim explained that section 906 has been expanded substantially, to directly incorporate more of the IFC requirements for portable fire extinguishers.

It was noted that sections 907.1.1 and 907.1.2 may be deleted so as to not redundantly address the plan submittal and construction oversight requirements that are addressed more comprehensively in chapter Comm 61. Chris asked if local governments could then still choose to apply sections 907.1.1 and 907.1.2, and the answer was yes, provided the application occurs through a local ordinance.

In reviewing section 907.2, Jim explained that criteria has been added for Group B ambulatory health care facilities in section 907.2.2.1 and in other applicable sections throughout the IBC, to better address medical clinics where care recipients may be anesthetized.

Jim noted the Commercial Building Code Advisory Council may review the shaftway-marking requirements in section 914.1.2, and the fire-pump acceptance testing in section 913.5.

Jim noted that recent Wisconsin statutory requirements for carbon monoxide alarms may be incorporated as modifications to the IBC.

The Council did not recommend any Wisconsin-based modifications to the 2009 IBC changes.

Current Wisconsin modifications to the IBC

In reviewing the current Wisconsin modifications of the IBC, which were sent to the Council members in advance of the meeting, Jim noted the Department will likely retain the modifications in sections Comm 62.0307, 62.0400, 62.0414, and 62.0415. Staff review of the modifications for fire sprinkler systems in Comm 62.0903 may result in some updates for the cross-references there to IBC sections – and may result in some deletions, such as for the

**MEDICAL EXAMINING BOARD
MEETING MINUTES
JANUARY 16, 2013**

PRESENT: James Barr; Mary Jo Capodice, DO; Sridhar Vasudevan, MD (*left the meeting at 9:56 A.M.*); Kenneth Simons, MD; Gene Musser, MD; Jude Genereaux; Sandra Osborn, MD; Greg Collins; Sheldon Wasserman, MD; Timothy Westlake, MD; Rodney Erickson, MD; Suresh Misra, MD, Timothy Swan, MD

STAFF: Tom Ryan, Executive Director (*left the meeting at 10:40 A.M.*); Dan Williams, Executive Director; Matthew Niehaus, Bureau Assistant; and other Department Staff

CALL TO ORDER

Dr. Sheldon Wasserman, Chair, called the meeting to order at 8:03 a.m. A quorum of thirteen (13) members was present.

ADOPTION OF AGENDA

Amendments to the Agenda

- Item “F” (open session) **REMOVE** the agenda item titled “Presentation of Petition for Summary Suspension in Case Number 11 MED 315, Giuditta Angelini, M.D.”
- Item “X” (closed session) **REMOVE** the agenda item titled “Deliberation of Petition for Summary Suspension in Case Number 11 MED 315, Giuditta Angelini, M.D.”
- Item “Y” (closed session) **REMOVE** the agenda item titled “Complaint for Determination of Probable Cause in Case Number 11 MED 315, Giuditta Angelini, M.D.”
- Item “U” (closed session) **ADD** the agenda item titled “Stephen R. Krueser, M.D. (10 MED 389)”

MOTION: Dr. Tim Westlake moved, seconded by Dr. Suresh Misra, to adopt the agenda as amended. Motion carried unanimously.

APPROVAL OF MINUTES OF DECEMBER 12, 2012

- Page 4 of the minutes designate absence of Dr. Sridhar Vasudevan during deliberation of Shirley Y. Godwalla, M.D.
- Page 4, note that at 12:12:12 on 12/12/12, Dr. Sridhar Vasudevan interrupted meeting to note the time and date

MOTION: Dr. Sridhar Vasudevan moved, seconded by, Dr. Kenneth Simons to approve the minutes of December 12, 2012 as published. Motion carried.

ELECTION OF OFFICERS AND APPOINTMENT OF PANELS, COMMITTEES, AND LIAISONS

Election of Officers

Chair

NOMINATION: Dr. Kenneth Simons nominated Dr. Sheldon Wasserman for the Office of Chair. Nomination carried by unanimous vote.

Tom Ryan called for other nominations three (3) times.

Dr. Sheldon Wasserman was elected as Chair.

Vice Chair

NOMINATION: Dr. Sridhar Vasudevan nominated Dr. Tim Swan for the Office of Vice Chair. Election failed.

NOMINATION: Dr. Gene Musser nominated Dr. Kenneth Simons for the Office of Vice Chair. Nomination carried by majority vote.

NOMINATION: Ms. Jude Genereaux nominated Dr. Suresh Misra for the Office of Vice Chair. Election failed.

Tom Ryan called for other nominations three (3) times.

Dr. Kenneth Simons was elected as Vice Chair.

Secretary

NOMINATION: Dr. Suresh Misra nominated Ms. Jude Genereaux for the Office of Secretary. Nomination carried by unanimous vote.

Tom Ryan called for other nominations three (3) times.

Ms. Jude Genereaux was elected as Secretary.

2013 ELECTION RESULTS	
Board Chair	Dr. Sheldon Wasserman
Vice Chair	Dr. Kenneth Simons
Secretary	Ms. Jude Genereaux

Appointment of Liaisons

MOTION: Dr. Gene Musser moved, seconded by Dr. Suresh Misra, that the record indicate election of Dr. Sheldon Wasserman as Chair, Dr. Kenneth Simons as Vice-Chair, and Ms. Jude Genereaux as Secretary, and the delegation of liaisons as discussed below. Motion carried unanimously.

Legal Services and Compliance Liaison

APPOINTMENT: Dr. Sheldon Wasserman appointed Dr. Sridhar Vasudevan (with Dr. Mary Jo Capodice as an alternate) as Legal Services and Compliance Liaison.

Professional Assistance Procedure (PAP) Liaison

APPOINTMENT: Dr. Sheldon Wasserman appointed Dr. Mary Jo Capodice (with Dr. Sridhar Vasudevan as an alternate) as Professional Assistance Procedure (PAP) Liaison.

Office of Education and Exams Liaison(s)

APPOINTMENT: Dr. Sheldon Wasserman appointed Dr. Kenneth Simons as Office of Education and Exams Liaison.

Website Liaison(s)

APPOINTMENT: Dr. Sheldon Wasserman appointed Dr. Timothy Swan as Website Liaison.

Credentialing Liaison(s)

APPOINTMENT: Dr. Sheldon Wasserman appointed Dr. Suresh Misra, Dr. Kenneth Simons, and Dr. Sheldon Wasserman (with Dr. Mary Jo Capodice and Dr. Timothy Westlake as alternates) as Credentialing Liaisons.

Legislative Liaison(s)

APPOINTMENT: Dr. Sheldon Wasserman appointed Dr. Timothy Swan, Dr. Timothy Westlake, Dr. Kenneth Simons, Dr. Sridhar Vasudevan, and Dr. Sheldon Wasserman as Legislative Liaisons.

Maintenance of Licensure Liaison(s)

APPOINTMENT: Dr. Sheldon Wasserman appointed Dr. Mary Jo Capodice and Dr. Rodney Erickson as Maintenance of Licensure Liaisons.

Newsletter Liaison(s)

APPOINTMENT: Dr. Sheldon Wasserman appointed Ms. Jude Genereaux as Newsletter Liaison.

Wis. Admin. Code Chapter MED 8 Liaison(s)

APPOINTMENT: Dr. Sheldon Wasserman appointed Dr. Gene Musser (with Dr. Timothy Westlake as an alternate) as Wis. Admin. Code Chapter MED 8 Liaison.

MOTION: Dr. Sridhar Vasudevan moved, seconded by Dr. Timothy Westlake, that, in order to facilitate the completion of assignments between meetings, the Board delegates its authority by order of succession to the Chair, highest ranking officer, or longest serving member of the Board, to appoint liaisons to the Department where knowledge or experience in the profession is required to carry out the duties of the Board in accordance with the law. Motion carried unanimously.

MOTION: Dr. Kenneth Simons moved, seconded by Dr. Gene Musser that the Board delegates authority to the Chair (or order of succession) to sign documents on behalf of the Board. In order to carry out duties of the Board, the Chair has the ability to delegate this signature authority for purposes of facilitating the completion of assignments during or between meetings. The Chair delegates the authority to the Executive Director, to sign the name of the Chair (or order of succession) on documents as necessary. Motion carried unanimously.

EXECUTIVE DIRECTOR MATTERS

Discussion and Consideration of Changing Date of April Meeting

MOTION: Dr. Kenneth Simons moved, seconded by Dr. Timothy Swan, to move the date of the April meeting to April 24, 2013. Motion carried unanimously.

MOTION: Dr. Kenneth Simons moved, seconded by Dr. Suresh Misra, to delegate authority to council delegates to advise on credentialing matters. Motion carried unanimously.

Dr. Sridhar Vasudevan left the meeting at 9:56 A.M.

WISCONSIN ADMINISTRATIVE CODE CHAPTER MED 10 – RULE WRITING STATUS

MOTION: Dr. Kenneth Simons moved, seconded by Dr. Rodney Erickson, to delegate authority to Dr. Sheldon Wasserman to approve MED 10 for the Board to go to Clearinghouse. Motion carried unanimously.

SPEAKING ENGAGEMENT, TRAVEL, AND PUBLIC RELATION REQUESTS

MOTION: Dr. Kenneth Simons moved, seconded by Dr. Rodney Erickson, to delegate Dr. Sheldon Wasserman with Dr. Mary Jo Capodice as alternates to the FSMB conference. Motion carried unanimously.

MOTION: Dr. Kenneth Simons moved, seconded by Dr. Rodney Erickson, to grant Tom Ryan authority to speak on the Board's behalf at the FSMB meeting on January 17, 2013. Motion carried unanimously.

Tom Ryan left the meeting at 10:40 A.M.

Dan Williams assumed the role of Executive Director at 10:40 A.M.

DISCUSSION AND CONSIDERATION OF ACGME POST-GRADUATE EDUCATION REQUIREMENT

MOTION: Dr. Timothy Swan moved, seconded by Ms. Jude Genereaux, to seek legislation that would:

- A) Require a temporary education permit at beginning of training that may last for the length of the residency and
- B) Set a minimum threshold for obtaining an unrestricted license of 3 successful years of ACGME/AOA accredited post-graduate medical education.

Motion carried unanimously.

DISCUSSION AND CONSIDERATION OF DUTIES TO REPORT PROFESSIONAL MISCONDUCT

MOTION: Dr. Gene Musser moved, seconded by Dr. Sandra Osborn, to request that DSPS staff create documentation for signature by the Board Chair relative to contacting the director of state courts regarding providing reports as required under Wis. Stat. 655.45: Reports to licensing bodies. Motion carried unanimously.

MOTION: Dr. Gene Musser moved, seconded by Dr. Sandra Osborn, to request that DSPS staff create documentation for signature by the Board Chair relative to contacting the compensation fund board of governors to request they provide the Board with reports as required under Wis. Stat. 655.26(2). Motion carried unanimously.

SCREENING PANEL REPORT

Ms. Jude Genereaux reported twenty (20) cases were screened. Ten (10) cases were opened.

CLOSED SESSION

MOTION: Dr. Gene Musser moved, seconded by Dr. Rodney Erickson, to convene to closed session pursuant to Wisconsin State statutes 19.85(1)(a)(b)(f) and (g) for the purpose of conducting appearances, reviewing monitoring requests, requests for licensure, deliberate on stipulations, administrative warnings, proposed decisions and orders, consulting with Legal Counsel and Division of Legal Services and Compliance case status reports. Roll Call Vote: James Barr-yes; Mary Jo Capodice, DO-yes; Jade Genereaux-yes; Sandra Osborn, MD-yes; Greg Collins-yes; Timothy Westlake, MD-yes; Rodney Erickson, MD-yes; Suresh Misra, MD-yes; Timothy Swan, MD-yes; Kenneth Simons, MD-yes; Gene Musser, MD-yes; and Sheldon Wasserman, MD-yes. Motion carried unanimously.

The Board convened into Closed Session at 12:03 p.m.

PLANNED PARENTHOOD LAWSUIT CHALLENGING 2010 WISCONSIN ACT 217

12:05 P.M. Appearance by Dan Lennington, Maria Lazar, Asst. Attorney Generals

MOTION: Dr. Sandra Osborn moved, seconded by Mr. Jim Barr, to acknowledge the appearance of Dan Lennington, and Maria Lazar from the Assistant Attorney General's office to address the Planned Parenthood Lawsuit regarding Wisconsin Act 217. Motion carried unanimously.

APPLICATION MATTERS

MOTION: Dr. Kenneth Simons moved, seconded by Dr. Suresh Misra, to find that Belmarie P. Roman Maradiaga, M.D.'s post-graduate training is equivalent to a year of ACGME accredited training. Motion carried unanimously.

MOTION: Dr. Gene Musser moved, seconded by Dr. Suresh Misra, to find that Sajid S. Khan, M.D.'s post-graduate training is not equivalent to a year of ACGME accredited training, and denies Applicant's request. **Reason for Denial:** The Board does not find Applicant's training to be equivalent to ACGME accredited training. Motion carried unanimously.

**DELIBERATION OF ADMINISTRATIVE WARNINGS, PROPOSED STIPULATIONS
AND FINAL DECISIONS AND ORDERS**

MOTION: Dr. Gene Musser moved, seconded by Dr. Suresh Misra, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Orders in the disciplinary proceedings against Paul K. Awa, M.D. (12 MED 132.) Motion carried unanimously.

MOTION: Dr. Sandra Osborn moved, seconded by Dr. Kenneth Simons, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Orders in the disciplinary proceedings against Edward J. Muellerleile, M.D. (12 MED 331.) Motion carried unanimously.

MOTION: Ms. Jude Genereaux moved, seconded by Dr. Kenneth Simons, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Orders in the disciplinary proceedings against Stephen R. Kreuser, M.D. (10 MED 389.) Motion carried unanimously.

MOTION: Dr. Timothy Swan moved, seconded by Dr. Kenneth Simons, to issue an administrative warning in the matter of 12 MED 333, J.E.M. Motion carried unanimously.

MOTION: Dr. Timothy Swan moved, seconded by Dr. Suresh Misra, to issue an administrative warning in the matter of 12 MED 333, T.M.M. Motion carried unanimously.

**ORDER GRANTING PARTIAL SUMMARY JUDGMENT AND PROPOSED DECISION
AND ORDER IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST
GRAHAM R. CASE, M.D., DHA CASE NO. SPS-11-0034 DOE CASE NO. 08 MED 249**

MOTION: Dr. Gene Musser moved, seconded by Dr. Kenneth Simons, to accept the proposed findings of fact and conclusions of law and vary the order to decline to impose discipline in the matter of Graham R. Case, M.D. (08 MED 249.)
REASON: based on the totality of the circumstances, the Board determines that no discipline is necessary to protect the public, rehabilitate the licensee, or for purposes of deterrence. Motion carried.

Dr. Timothy Swan voted nay.

CASE CLOSINGS

- MOTION:** Dr. Tim Westlake moved, seconded by Dr. Kenneth Simons, to close the case #11MED148 for Prosecutorial Discretion (P3). Motion carried unanimously.
- MOTION:** Dr. Tim Westlake moved, seconded by Dr. Sandra Osborn, to close the case #12MED251 for No Violation (NV). Motion carried unanimously.
- MOTION:** Dr. Timothy Swan moved, seconded by Mr. Greg Collins, to close the case #12MED311 for No Violation (NV). Motion carried unanimously.
- MOTION:** Dr. Suresh Misra moved, seconded by Dr. Timothy Swan, to close the case #12MED380 for No Violation (NV). Motion carried unanimously.
- MOTION:** Mr. Greg Collins moved, seconded by Dr. Sandra Osborn, to close the case #12MED197 for No Violation (NV). Motion carried unanimously.
- MOTION:** Dr. Sandra Osborn moved, seconded by Dr. Timothy Westlake, to close the case #11MED217 for Prosecutorial Discretion (P3). Motion carried unanimously.
- MOTION:** Dr. Rodney Erickson moved, seconded by Dr. Suresh Misra, to close the case #12MED300 for Prosecutorial Discretion (P3). Motion carried unanimously.
- MOTION:** Dr. Kenneth Simons moved, seconded by Dr. Timothy Swan, to close the case #12MED110 for No Violation (NV). Motion carried unanimously.

Dr. Timothy Westlake recused himself from deliberation and voting in the matter of 12 MED 110.

- MOTION:** Ms. Jude Genereaux moved, seconded by Dr. Suresh Misra, to close the case #12MED332 for No Violation (NV). Motion carried unanimously.
- MOTION:** Dr. Suresh Misra moved, seconded by Dr. Timothy Swan, to close the case #12MED257 for Insufficient Evidence (IE). Motion carried unanimously.
- MOTION:** Dr. Kenneth Simons moved, seconded by Dr. Timothy Swan, to close the case #12MED271 for No Violation (NV). Motion carried unanimously.
- MOTION:** Ms. Jude Genereaux moved, seconded by Mr. Greg Collins, to close the case #12MED028 for No Violation (NV). Motion carried unanimously.

RATIFY ALL LICENSES AND CERTIFICATES

- MOTION:** Dr. Sandra Osborn moved, seconded by Dr. Suresh Misra, to ratify all licenses and certificates as issued. Motion carried unanimously.

RECONVENE TO OPEN SESSION

MOTION: Dr. Kenneth Simons moved, seconded by Dr. Suresh Misra, to reconvene into open session. Motion carried unanimously.

The Board reconvened into Open Session at 2:02 p.m.

VOTING ON ITEMS CONSIDERED OR DELIBERATED ON IN CLOSED SESSION

MOTION: Dr. Timothy Swan moved, seconded by Dr. Suresh Misra, to affirm all motions made in closed session. Motion carried unanimously.

ADJOURNMENT

MOTION: Dr. Suresh Misra moved, seconded by Dr. Gene Musser, to adjourn the meeting. Motion carried unanimously.

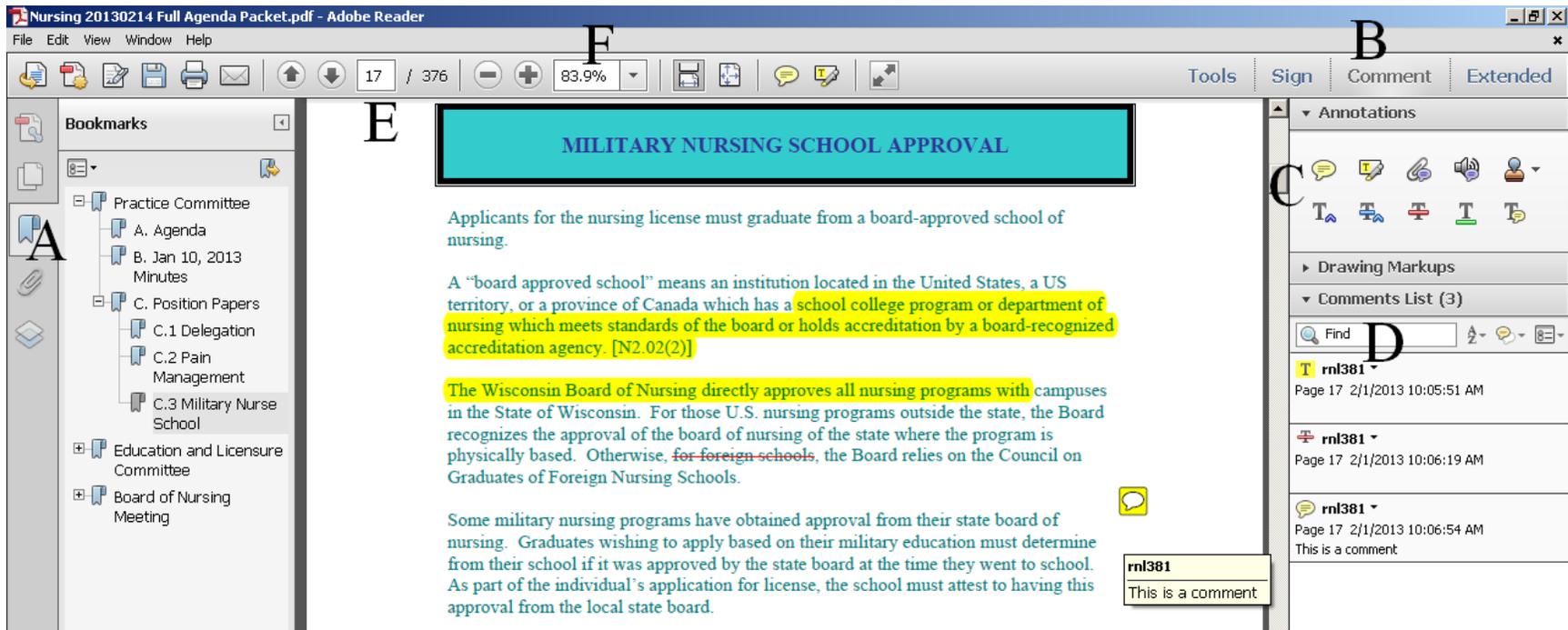
The meeting adjourned at 2:04 p.m.

Page intentionally left blank

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Matthew C. Niehaus, Bureau Assistant		2) Date When Request Submitted: 2/8/2013 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: 2/20/2013	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Paperless Initiative	
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? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Assistance for Board members in using data on the SharePoint site, as well as using Adobe Reader to insert comments into the agenda packet.			
11) Authorization			
Matthew C. Niehaus			
Signature of person making this request			Date
Supervisor (if required)			Date
Executive Director signature (indicates approval to add post agenda deadline item to agenda)			
Date			
Directions for including supporting documents: <ol style="list-style-type: none"> 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 Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting. 			



Above is an example of an agenda packet page, with some features you can access through Adobe Reader.

A: Bookmarks – When the Bureau Assistant creates the Agenda Packet, it is possible to place in bookmarks for quick reference during meetings. You can expand and minimize categories to better enable you to jump from section to section of your agenda here.

B: Comment – On specially designated .pdf files, it is possible for Adobe Reader to be given comment privileges. This allows a Board member to make comments on documents, as well as edit, highlight, or insert text in suitable files. Please note, if the file is a scanned copy, it is likely that the highlight and text editing features will not be usable. The comment feature will still work in such an issue.

C: Annotations & Drawing Markups – These are the different options you can use to mark up your document for your reference. If you mouse over an option, it will give a brief description of what it can do for you. Feel free to experiment and find out what works best for you!

D: Comments List – Quickly jump between your comments by selecting them in this list. Never again will you miss out on a note during a discussion with this handy tool.

E: Page List – No more rifling through papers in order to track down that page someone mentioned! With this handy bar, you can simply type in the page you are looking for, hit enter, and Adobe Reader will take you directly to the page.

F: Zoom – Having trouble reading something? You can zoom in and out on a document with this bar. The plus and minus signs to the left can be used to make quick adjustments as well.

**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: 2-8-2013	
		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: February 20, 2013	5) Attachments: x Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? MEB Newsletter	
7) Place Item in: x 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: Discuss newsletter content.			
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

Page intentionally left blank

**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: 2-8-13	
		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: February 20, 2013	5) Attachments: x Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Review of April meeting attendance, screening and examination assignments	
7) Place Item in: x 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: Check for quorum at the April meeting and clarify assignments for the April screening and examination panels.			
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	

Page intentionally left blank

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Jim Barr		2) Date When Request Submitted: 2-8-2013	
		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: February 20, 2013	5) Attachments: <input type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Professional Assistance Procedure (PAP) Overview	
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? Yes – Patara Horn, DSLC	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Patara Horn will review the PAP.			
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

Page intentionally left blank

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Gene Musser		2) Date When Request Submitted:	
		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: January 16, 2013	5) Attachments: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6) How should the item be titled on the agenda page? ACGME Post Graduate Education Requirement	
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: Wisconsin has a one year post-graduate (residency) training requirement. Dr. Musser asked that the Board discuss this, and Dr. Wasserman asked that it be scheduled for this 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	

Page intentionally left blank

**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: January 16, 2013	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Board Review of Position Statements, ALJ Decision and Position Papers	
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: All Boards will be reviewing position statements, position papers and other website content to ensure they are not outdated and comply with statutes, rules and Executive Order 50, relating to guidelines for the promulgation of administrative rules. The following options are suggested for undertaking this assignment, with a report back to the Board at the next meeting:			
<ol style="list-style-type: none"> 1. Appoint a member of the Board to review the position statements, ALJ decision and position papers; 2. Divide the position statements, ALJ decision and position papers; 3. All Board members could review the the statements, ALJ decision and position papers individually. 			
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	



STATE OF WISCONSIN

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

Mail to:
PO Box 8935
Madison WI 53708-8935

Email: dsps@wisconsin.gov
Web: <http://dsps.wi.gov>
Phone: 608-266-2112

Governor Scott Walker Secretary Dave Ross

**Positions Statements Related to Physicians
Issued by the Medical Examining Board**

UNDER WHAT CIRCUMSTANCES MAY A PHYSICIAN DELEGATE TO A NON-PHYSICIAN AN ACT THAT CONSTITUTES THE PRACTICE OF MEDICINE AND SURGERY?

Wis. Stat. § 448.03(2)(e) permits physicians to delegate to any unlicensed person an act that constitutes the practice of medicine and surgery. The physician must have the power to “direct, decide and oversee the implementation” of the patient service. The physician must, in fact, direct, supervise and inspect the delegated service.

Because a delegate is not licensed, a delegate performs the medical act under the authority of the physician’s license. Therefore, for regulatory purposes, the physician is responsible for the acts of the delegate.

As explained below, the supervising physician:

- must be competent to perform the act being delegated;
- must insure that the delegate is minimally competent to perform the act;
- and must make it clear to the patient and others that the delegate is an unlicensed person, performing the act under the supervision of the physician.

Wisconsin Admin. Code § MED10.02(2)(h) prohibits a physician from engaging in any practice or conduct that falls below the level of minimal competence and that places a patient at unacceptable risk of harm. The same rule directs that a physician may not aid or abet another person in incompetently placing a patient at unacceptable risk of harm.

Therefore, to competently supervise and oversee a delegate, the physician must be competent to perform the act in question, and must have reasonable evidence that the delegate is minimally competent to perform the act under the circumstances.

Wisconsin Admin. Code § MED10.02(2)(t) requires that a physician identify a delegate as being unlicensed and acting under the supervision of the physician. Failure to do so is considered “aiding or abetting the unlicensed practice of medicine” or representing that the unlicensed persons are licensed.

Although not specifically required in law, professional standards may require written protocols concerning delegated medical acts. If such practice standards exist, and a written protocol does not exist, physicians could be deemed to be in violation of Wis. Stat. Admin. Code § 10.02(2)(h). Hospitals are required to specify in by-laws those classes of employees that may accept and carry out physician orders – this may also include delegated acts. See Wis. Admin Code ch DHS 124.

MUST A PHYSICIAN BE PRESENT IN THE ROOM WHEN A DELEGATED MEDICAL ACT IS PERFORMED BY AN UNLICENSED PERSON?

As explained in response to question no. 1 above, the performance of a delegated medical act must be “directed, supervised and inspected” by a licensed physician. For the Board’s purposes, the physician is responsible for the act in question, and must insure that, under the circumstances present with each act, the delegate is competent to perform the act. The circumstances of each delegated act include the level of supervision under which the act is performed.

The law does not specify any particular level of supervision for acts performed by an unlicensed person under the physician’s supervision.

Therefore, the level of supervision a physician must provide an unlicensed person performing a delegated act is within the discretion of the supervising physician. Adequate supervision of a delegated act does not necessarily require that the physician be present when the act is performed if the physician reasonably determines that his or her absence does not place a patient at unacceptable risk of harm under the circumstances. For example, a simple procedure, with minimal risk of minimal harm and in the hands of an experienced delegate may require only general supervision, ie, the physician is not required to be physically present but is available by telephone. In some circumstances, a physician may require direct supervision, meaning the physician is present in the building and immediately available to assist in the procedure; in other cases, the physician may determine that direct face-to-face supervision is required to insure an adequate level of patient safety.

UNDER WHAT CIRCUMSTANCES MAY A NON-PHYSICIAN WHO IS A LICENSED HEALTH CARE PROFESSIONAL PERFORM ACTS CONSTITUTING THE PRACTICE OF MEDICINE AND SURGERY?

Some acts constituting the practice of medicine and surgery may also fall within the scope of practice of another license, such as a license to practice nursing or a license to practice as a physician assistant. In the case of a licensed professional, the licensed non-physician generally performs the act under the authority of his or her own license and attendant requirements (which may include physician supervision). Therefore, a nurse may independently perform acts within the scope of a license to practice nursing even if the act is also within the scope of a license to practice medicine and surgery.

Conversely, physician assistant licenses require PA's to perform medical services under the supervision of a physician. A physician assistant may not practice independently and may not independently perform acts outside the scope of a license to practice as a physician assistant. Therefore, for regulatory purposes, the responsibility to insure adequate physician supervision is the responsibility of both the supervising physician and the physician assistant, and for the Board's purposes, both are responsible for the service provided.

For guidance on scope of practice for licensed professionals, please see statutes and administrative rules pertaining to the relevant profession(s).

MAY A PHYSICIAN PRACTICE MEDICINE WITHIN A PARTNERSHIP OR SERVICE CORPORATION?

Wisconsin Stat. § 448.08(4) provides that two or more physicians may, in the practice of medicine and surgery, enter into professional partnerships or service corporations. Please see Wis. Stat. § 448.08 concerning business practices for physicians and if additional guidance is necessary, you may wish to consult private counsel.

WHAT ARE REQUIREMENTS FOR A PHYSICIAN WHO SELF-IDENTIFIES AS "BOARD CERTIFIED"?

Wisconsin Admin. Code § MED 10.02(w) requires truthful disclosure of any claim to board certification or similar phrase. If a physician--by affirmative conduct or by omission--misrepresents themselves as board certified in a particular specialty area, by a particular certifying organization or without current certification, the Board may determine that the physician has engaged in unprofessional conduct and the physician may be subject to disciplinary action.

WHAT IS THE LENGTH OF TIME THAT A PHYSICIAN IN WISCONSIN MUST RETAIN PATIENT MEDICAL RECORDS?

Wisconsin Admin. Code § MED 21.03, Minimum Standards for Patient Health Care Records, requires that a physician or a physician's assistant shall maintain patient health care records for a period of not less than five (5) years after the date of the last entry, or for such longer period as may be otherwise required by law. Wisconsin Stat. § 146.819 also concerns preservation or destruction of patient health care records.

ARE SILICONE INJECTIONS LEGAL IN WI?

There is no statutory or administrative code that specifically prohibits the use of silicone injections. While the U.S. Food and Drug Administration banned silicone injections in 1992, there may be recent developments in technology and the practice of medicine that were not addressed in the 1992 ban. Physicians must not engage in any practice or procedure that violates state or federal law or that falls below the level of minimal competence and creates an

unacceptable risk of harm. Physicians may wish to consult private counsel if they have any question concerning legality of any medical device or medication.

MAY A PHYSICIAN DELEGATE DISPENSE SAMPLE MEDICATIONS TO A PATIENT?

Yes, a physician may delegate an unlicensed person to dispense sample medications to a patient subject to legal requirements, including controlled substances and record-keeping requirements. See general requirements for physician delegation in FAQ No. 1 and the rule concerning prescribing at Wis. Admin Code ch. MED 17.

WHERE MAY ONE FIND GUIDANCE ON PHYSICIAN DISPENSING OF MEDICATIONS?

In addition to Wis. Stat chs. 448 and 961, persons with questions concerning physician dispensing of medication may wish to consult Wisconsin Admin. Code ch. MED17, as well as PHAR ch. 8. Another relevant resource is the United States Drug Enforcement Administration's Practitioner's Manual which is available online at:

www.deadiversion.usdoj.gov/pubs/manuals/pract/index.html

DOES WISCONSIN RECOGNIZE NATUROPATHIC DOCTORS?

Wisconsin law does not recognize naturopathic physician education and training. A doctor that is registered and licensed as a naturopathic physician in another state is not qualified for licensure as a physician in Wisconsin unless he or she meets the licensure requirements set forth in Wis. Ch. 448 and Wis. Admin. Code ch. MED 1.

WHAT ARE THE REQUIREMENTS FOR MAINTAINING A VALID WISCONSIN MEDICAL LICENSE AFTER RETIRING OR OTHERWISE VOLUNTARILY REFRAINING FROM THE ACTIVE PRACTICE OF MEDICINE?

Maintaining a medical license requires a renewal fee and completion of 30 hours of biennial continuing medical education. See Wis. Admin. Code chs. MED 13 and 14. Wisconsin law does not authorize a license specifically for retired or inactive physicians. To maintain a license to practice medicine and surgery all requirements for full licensure must be met, including fees and biennial continuing education.

In deciding whether or not to allow a medical license to lapse during any period of inactivity, physicians may wish to review Wis. Admin. Code § MED 1.06(1)(a)11, which permits the Board to require an oral examination prior to issuing or reinstating the license of any physician who, prior to application, has not engaged in practice for a period of three years or more. At oral examination, the Board can be expected to inquire about activities the physician has undertaken to maintain professional competence. The Board may require additional competency evaluation, or training—including a residency—or both, prior to permitting the inactive physician to become licensed.

MAY WISCONSIN PHYSICIANS PRESCRIBE EITHER NON-CONTROLLED OR CONTROLLED SUBSTANCES FOR THEMSELVES OR THEIR FAMILY MEMBERS?

Wisconsin Stat. § 961.38(5) criminalizes self-prescribing of controlled substances as well as the act of taking a controlled substance without a valid prescription.

Wisconsin law does not explicitly prohibit self-prescribing of non-controlled substances, nor prescribing medications for family members. Despite the absence of specific statutory prohibitions, the Board may consider whether the circumstances of any particular prescription constitute unprofessional conduct under Wis. Admin. Code § 10.02(2)(h) (contrary to minimally competent practice and creating an unacceptable risk of harm to the physician or family member). Finally, physicians should consider whether prescribing controlled substances to a family member comports with requirements of the federal Drug Enforcement Administration (DEA).

In addition to insuring patient safety, physicians are responsible for all other requirements of competent and lawful practice, including but not limited to record keeping as required in Wis. Stat. § 146.816 and Wis. Admin. Code ch. 21.

HAS THE WISCONSIN MEDICAL EXAMINING BOARD ADOPTED SPECIFIC GUIDELINES FOR PHYSICIANS WHO ARE TREATING CHRONIC PAIN OR PRESCRIBING CONTROLLED SUBSTANCES FOR THE TREATMENT OF PAIN?

No, the Board has not officially adopted or issued any specific guidelines *per se*, however, the Board has indicated that if a physician follows the Model Guidelines for Use of Controlled Substances for Treatment of Pain adopted by the Federation of State Medical Board (FSMB), the physician would be practicing within the standard of care of a competent physician.

The current FSMB guidelines can be referred to by clicking [here](#).

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF A PETITION FOR
DECLARATORY RULING INVOLVING

WISCONSIN SOCIETY OF
ANESTHESIOLOGISTS,
PETITIONER,

and

FINAL DECISION ON
PETITIONER'S MOTION FOR
SUMMARY JUDGMENT
AND FINAL ORDER
DISMISSING PETITION FOR
DECLARATORY RULING

LS0511012MED

GOVERNOR JIM DOYLE,
ATTORNEY GENERAL J.B. VAN HOLLEN,
CENTERS FOR MEDICARE AND MEDICAID SERVICES,
PODIATRISTS AFFILIATED CREDENTIALING BOARD,
WISCONSIN ASSOCIATION OF NURSE ANESTHETISTS,
WISCONSIN BOARD OF NURSING,
WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES,
WISCONSIN DEPARTMENT OF REGULATION AND LICENSING,
WISCONSIN HOSPITAL ASSOCIATION,
WISCONSIN MEDICAL SOCIETY, and
WISCONSIN SOCIETY OF PODIATRIC MEDICINE,

INTERESTED PARTIES.

The State of Wisconsin, Medical Examining Board, having considered the above-captioned matter and having reviewed the record and the Proposed Decision of the Administrative Law Judge, makes the following:

ORDER

NOW, THEREFORE, it is hereby ordered that the Proposed Decision annexed hereto, filed by the Administrative Law Judge, shall be and hereby is made and ordered the Final Decision of the State of Wisconsin, Medical Examining Board.

The rights of a party aggrieved by this Decision to petition the department for rehearing and the petition for judicial review are set forth on the attached "Notice of Appeal Information."

Dated this 15th day of August, 2007.

Gene Musser MD
Member of the Board
Medical Examining Board

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

In the Matter of a Petition for
Declaratory Ruling involving,

WISCONSIN SOCIETY OF
ANESTHESIOLOGISTS,

PETITIONER,

and

PROPOSED DECISION ON PETITIONER'S
MOTION FOR SUMMARY JUDGMENT AND
PROPOSED ORDER DISMISSING PETITION
FOR DECLARATORY RULING

Case No. LS0511012MED

GOVERNOR JIM DOYLE,
ATTORNEY GENERAL J.B. VAN HOLLEN,
CENTERS FOR MEDICARE AND MEDICAID SERVICES,
PODIATRISTS AFFILIATED CREDENTIALING BOARD,
WISCONSIN ASSOCIATION OF NURSE ANESTHETISTS,
WISCONSIN BOARD OF NURSING,
WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES,
WISCONSIN DEPARTMENT OF REGULATION AND LICENSING,
WISCONSIN HOSPITAL ASSOCIATION,
WISCONSIN MEDICAL SOCIETY, and
WISCONSIN SOCIETY OF PODIATRIC MEDICINE,

INTERESTED PARTIES.

The parties to this action for purposes of Wis. Stat. § 227.53, are:

Petitioner:

Wisconsin Society of Anesthesiologists
Attorney Michael G. Laskis
Foley & Lardner LLP
150 East Gilman Street
P.O. Box 1497
Madison, WI 53701-1497

Interested Parties:

Governor Jim Doyle
P.O. Box 7863
Madison, WI 53707
Wisconsin Hospital Association
P.O. Box 259038
Madison, WI 53725-9038
Wisconsin Medical Society
330 East Lakeside Street
P.O. Box 1109
Madison, WI 53701-1109
Wis. Soc. of Podiatric Medicine
Attorney Stan Davis
Quarles and Brady, LLP
One South Pinckney Street, Suite 600
Madison, WI 53703-2808
Wisconsin Dept. of Reg. and Licensing
Steve Gloe, General Counsel
Wisconsin Dept. of Reg. and Licensing
Box 8935
Madison, WI 53708-8935

Wisconsin Medical Examining Board

Attorney General J.B. Van Hollen
P.O. Box 7857
Madison, WI 53707-7857
Wis. Dept. of Health and Family Services
One West Wilson Street
Madison, WI 53702
Centers for Medicare and Medicaid Services
314 G. Hubert Humphrey Building
200 Independence Avenue S.W.
Washington DC 20201
Wis. Association of Nurse Anesthetists
Attorney Stan Davis
Quarles and Brady, LLP
One South Pinckney Street, Suite 600
Madison, WI 53703-2808
Wisconsin Board of Nursing
Attorney Colleen Baird
Office of Legal Counsel
Wisconsin Dept. of Reg. and Licensing
P.O. Box 8935
Madison, WI 53708-8935
Podiatrists Affiliated Credentialing Board

Attorney Peggy Wichmann
Office of Legal Counsel
Wisconsin Dept. of Reg. and Licensing
P.O. Box 8935
Madison, WI 53708-8935

Attorney Jacquelynn Rothstein
Office of Legal Counsel
Wisconsin Dept. of Reg. and Licensing
P.O. Box 8935
Madison, WI 53708-8935

INTRODUCTION

The Medical Examining Board decides in this case whether to issue an order declaring that the administration of anesthesia by a certified registered nurse anesthetist (CRNA) must be performed under the supervision of a physician. A CRNA is a nurse licensed as a registered nurse (RN) under Wis. Stat. ch 441 and certified by the American Association of Nurse Anesthetists as a "certified registered nurse anesthetist."^[1]

The root of this controversy is a June 6, 2005, letter submitted by Governor Jim Doyle to the Administrator of the federal Centers for Medicare and Medicaid Services (CMS) requesting exemption (an opt-out) from the federal requirement for physician supervision of CRNAs. Governor Doyle's letter was sent pursuant to amendments made in 2001 to federal regulations relating to the Anesthesia Services Condition of Participation for Hospitals, the Surgical Services Condition of Participation for Critical Access Hospitals, and the Surgical Services Condition of Coverage for Ambulatory Surgical Centers. The 2001 amendments changed a longstanding CMS policy requiring physician supervision of the anesthesia care provided by CRNAs. The amendments permit hospitals and surgical centers to obtain exemptions from the CMS requirement for physician supervision of CRNAs if the state submits a letter to CMS signed by the Governor, requesting exemption from physician supervision of CRNAs.^[3]

DECISION SUMMARY

Administration of anesthesia by a CRNA is part of the practice of medicine and surgery. Administration of anesthesia is also part of the practice of professional nursing by CRNAs, but not within the scope of professional nursing practice for nurses who are not CRNAs.

The law administered by the Medical Examining Board requires generally that a person be licensed as a physician to practice medicine and surgery. An exception in the law exists for persons lawfully practicing within the scope of a certificate granted to practice professional nursing by the Board of Nursing (BON).

A CRNA who is certified as an Advanced Practice Nurse Prescriber (APNP) and who administers anesthesia is lawfully practicing within the scope of a certificate granted to practice professional nursing and comes within the exception. This exception does not require that a physician supervise the CRNA. Prior to November 1, 2000, the BON and its staff had interpreted the law to require that all CRNAs administer anesthesia under the supervision of a physician. However, a specific directive adopted by the Board of Nursing in administrative rules, effective November 1, 2000, requires that an APNP work in a collaborative relationship with a physician.

A CRNA who is not certified as an APNP and who administers anesthesia is not practicing within the scope of a certificate as an APNP. A CRNA who is not an APNP is not subject to the BON's requirements for APNPs, including the rule requiring collaboration with a physician. A CRNA who is not an APNP may administer anesthesia only under the supervision of a physician, a requirement unchanged by the BON rule effective in 2000.

This decision is supported by the substance and legislative history of 1993 Act 138, by BON rulemaking under Act 138, and by statutes that are related to the practice of a CRNA such as provisions governing liability insurance for health care providers in Wis. Stat. ch. 655 and administrative rules regulating hospitals in Wis. Adm. Code § HFS 124.

PROCEDURAL HISTORY

Petitioner, the Wisconsin Society of Anesthesiologists (WSA), filed a Petition for Declaratory Ruling on July 25, 2005, and an Amended Petition for Declaratory Ruling dated January 13, 2006, with proposed findings of fact and conclusions of law. Responsive materials including proposed findings and conclusions were filed by four interested parties: Wisconsin Board of Nursing (BON), Wisconsin Association of Nurse Anesthetists (WANA), Wisconsin Society of Podiatric Medicine (WSPM), and Wisconsin Podiatry Affiliated Credentialing Board (PACB). Petitioner supplemented its Amended Petition on April 17, 2006.

On June 30, 2006, Petitioner WSA filed a Motion For Summary Judgment with supporting documents. Briefs and other responsive materials were filed by interested parties, BON, WANA, WSPM and PACB. Reply materials were filed by the WSA on September 22, 2006. ^[4]

PETITION FOR DECLARATORY RULING

A declaratory ruling is an order in which an agency declares the rights, duties, status, or other legal relations between the parties and is similar to a declaratory judgment issued by a court. A court action for a declaratory judgment is the appropriate remedy to resolve a controversy where there may be doubt about legal rights and the plaintiff wishes to avoid the hazard of taking action in advance of a court determination. Declaratory judgments are intended to resolve uncertainties and controversies.^[5]

The WSA's petition was filed under Wis. Stat. § 227.41 which, in part, states:

Wis. Stat. § 227.41. Declaratory rulings. (1) Any agency may, on petition by any interested person, issue a declaratory ruling with respect to the applicability to any person, property or state of facts of any rule or statute enforced by it. . . .

The word "may" as used in Wis. Stat. § 227.41(1) grants the Board discretionary authority as to whether it will issue a declaratory ruling. Parties are not entitled to a declaratory ruling as a matter of right.^[6]

Petitioner WSA contends that Governor Doyle erred when he requested an opt-out and that a declaratory ruling by the Medical Examining Board (MEB) is needed to eliminate reliance on the Governor's error. The WSA asserts that physicians who rely on the erroneous letter may be judged guilty of unprofessional conduct and further, may be liable for negligence if a patient is injured as a result of a physician's failure to supervise a CRNA. Also, according to the WSA, a CRNA who administers anesthesia without physician supervision may be denied malpractice insurance coverage.^[7]

MOTION FOR SUMMARY JUDGMENT

The matter under present consideration before the Medical Examining Board is Petitioner WSA's June 30, 2006, Motion for Summary Judgment requesting that the MEB issue a ruling declaring that the administration of anesthesia by CRNAs must be performed under the supervision of a physician (or under the supervision of a podiatrist or dentist in cases where the Wisconsin Statutes permits such supervision).

The primary purpose of summary judgment procedure is to eliminate trial in cases in which a trial is unnecessary. A motion for summary judgment tests whether there are any disputed issues of fact.^[8] Summary judgment also promotes the search for undisputed material facts.^[9]

State agencies are authorized by Wis. Stat. § 227.42(1)(d) to develop summary disposition procedures, such as summary judgment, where the disposition does not require the resolution of any dispute of material fact.^[10] Summary judgment procedures under Wis. Stat. § 802.08, applicable to civil actions before a court, are used here in responding to Petitioner WSA's motion. Under the methodology used by courts, the pleadings are examined to determine whether a claim for relief has been stated. If so, the inquiry shifts to whether any factual issues exist. Summary judgment must be entered ". . . if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law."^[11]

Petitioner's Amended Petition for Declaratory Ruling meets the requirements of a petition under Wis. Stat. § 227.41. Through proposed facts, responses and the submittal of affidavits and other materials, the parties have established the material facts relating to the administration of anesthesia. The remaining summary judgment issue is whether the moving party is entitled to a judgment as a matter of law.

BOARD RESPONSIBILITIES AND STRUCTURE

The practices of medicine and surgery and of professional nursing are regulated by the state under Wis. Stat. chs. 448 and 441, respectively, to protect public health, safety and welfare. Professional licensing boards are created to assure the competence of the licensed practitioner.^[12] Like other statutes licensing the professions, chs. 441 and 448 were not enacted for the benefit of the persons licensed, but for the benefit and protection of the public.^[13]

Within the organizational structure of Wisconsin state government, both the Medical Examining Board and the Board of Nursing are "examining boards."^[14] By statute each examining board:

Shall promulgate rules for its own guidance and for the guidance of the trade or profession to which it pertains, and define and enforce professional conduct and unethical practices not inconsistent with the

law relating to the particular trade or profession.[15]

Under Wis. Stat. § 227.10(1), “[e]ach agency shall promulgate as a rule each statement of general policy and each interpretation of a statute which it specifically adopts to govern its enforcement or administration of that statute.”[16]

The MEB and BON are attached to the Department of Regulation and Licensing (DRL) and subject to statutory duties including the general obligation of each to “[i]ndependently exercise its powers, duties and functions prescribed by law with regard to rule-making, credentialing and regulation.”[17] Each board’s independent authority is subject to legislative oversight, including review of rulemaking under Wis. Stat. 227.19. Any dispute between an examining board and the DRL secretary is to be arbitrated by the governor.[18]

Interested party PACB is an “affiliated credentialing board” attached to the Medical Examining Board. [19] By statute, the PACB is to regulate with advice from the MEB. The PACB chairperson is to meet at least once every 6 months with the MEB to consider matters of joint interest.[20]

The term “*in pari materia*” refers to statutes relating to the same subject matter or having the same common purpose. Wis. Stat. chs 448 and 441 relate to the same subject matter and have the common goal of assuring the public that Wisconsin physicians and nurses are competent and protecting the welfare and safety of health care patients. As a rule of statutory interpretation, statutes *in pari materia* are read and construed together in harmony to achieve their common goal.[21]

FINDINGS OF FACT – ADMINISTRATION OF ANESTHESIA

Findings of Fact set forth below describe: the basic nature of anesthesia practice, (paragraphs 1 – 5), providers of anesthesia care and their qualifications (paragraphs 6 – 12), the anesthesia-related care typically provided to a patient before surgery (paragraph 14), the administration of anesthesia typically provided during a surgical procedure (paragraphs 16 – 23), and examples of emergency anesthesia complications (paragraphs 24 – 27). These findings were developed utilizing summary judgment procedures permitting a party to propose findings of fact and to contest proposed findings made by another party on the basis of admissible evidence.[22] A proposed factual finding may be included despite objections to the proposed finding if the proposed finding is material to the issues and no supporting affidavits or other factual evidence is submitted to support the objection.

LICENSE REQUIRED TO PRACTICE MEDICINE AND SURGERY

The “practice of medicine and surgery” is defined in Wis. Stat. § 448.01(9).[23] The definition is expansive and there is no doubt that the practice includes the administration of anesthesia. Wis. Stat. § 448.03(1)(a) requires a person to have a license as a physician to practice medicine and surgery:

No person may practice medicine and surgery, or attempt to do so or make a representation as authorized to do so, without a license to practice medicine and surgery granted by the board.

There are exceptions to this physician licensing requirement in Wis. Stat. § 448.03(2), including the following:

Nothing in this subchapter shall be construed either to prohibit, or to require, a license or certificate under this subchapter for any of the following:

- (a) Any person lawfully practicing within the scope of a license, permit, registration, certificate or certification granted to practice professional or practical nursing or nurse-midwifery under ch. 441, to practice chiropractic under ch. 446, to practice dentistry or dental hygiene under ch. 447, to practice optometry under ch. 449, to practice acupuncture under ch. 451 or under any other statutory provision, or as otherwise provided by statute.
- (b) . . .
- (c) Any person other than a physician assistant who is providing patient services as directed, supervised and inspected by a physician who has the power to direct, decide and oversee the implementation of the patient services rendered.

The exception in § 448.03(2)(a) for non-physicians lawfully practicing within the scope of another credential reflects the legal principle that the practice of the health care professionals may overlap.

Overlap in the scope of professional practice has been discussed in opinions of the Wisconsin Attorney General.

The courts and this office have also recognized that the disciplines of various health care professionals may overlap. In *Kerkman*, 142 Wis. 2d at 416, the court recognized that "although chiropractors are permitted to use some medical tools when analyzing and treating a patient, this overlap does not transform the practice of chiropractic into the practice of medicine." In 68 Op. Att'y Gen. 316 (1979), my predecessor concluded that a physician could advise a patient whether continued chiropractic care was necessary without engaging in the unauthorized practice of chiropractic, even though that advice may technically fall within the definition of chiropractic practice. . . .

" . . . In giving advice to patients, there is an overlap between what may properly be done by a chiropractor and a physician under their respective grants of statutory authority. In my view, a physician is given the latitude to perform services within his or her authority, whether those services overlap with professional services properly performed by a chiropractor, or other health care professional.

"To find otherwise would be to place unreasonable restraints on the practice of medicine. As summarized by the court in *Smith v. American Packing & Provision Co.*, 102 Utah 351, 130 P.2d 951, 955 (1942), "the mere fact that a licensed profession extends in some degree into the field of some other licensed occupation, does not require the licensee to have a license in each of the fields into which his profession may overlap, unless the statutes impose such requirement." . . . [25]

The statute administered by the Medical Examining Board does not impose a requirement that a listed health care professional whose practice lawfully extends into the practice of medicine and surgery be licensed as a physician. Exceptions to the physician licensing requirement in Wis. Stat. § 448.03(2)(a) acknowledges the possibility of overlap and provides a means of accommodating the situation by recognizing another license or requiring physician supervision.

ISSUE PRESENTED

The petition presents the issue of whether a CRNA who administers anesthesia without physician supervision is unlawfully practicing medicine and surgery.

If a CRNA who administers anesthesia is lawfully practicing within the scope of a certificate to practice professional nursing granted under ch. 441, the above Wis. Stat. § 448.03(2)(a) exception to the general rule applies and the CRNA is not required by Wis. Stat. § 448.03(1)(a) to have a license to practice medicine or surgery or be supervised by a physician. However if a CRNA is not lawfully practicing within the scope of a certificate granted under ch. 441, then the CRNA may administer anesthesia under the exception to the general rule in Wis. Stat. § 448.03(2)(e) that permits any person to provide patient services, but the services must be provided ". . . as directed, supervised and inspected by a physician who has the power to direct, decide and oversee the implementation of the patient services rendered."

As described below, a CRNA who is certified by the BON as an APNP (CRNA/APNP) and works in a collaborative relationship with a physician, and who administers anesthesia, is lawfully practicing within the scope of a certificate granted to practice professional nursing under ch. 441. This conclusion is supported by the statutory definition of professional nursing, the law authorizing certification of APNPs, rules adopted by the Board of Nursing to implement the APNP law, and laws related to CRNA practice such as the health care liability statutes and state rules regulating hospitals. CRNAs who are not APNPs do not meet the terms of this exception.

CREDENTIALING, SUPERVISION AND COLLABORATION REQUIREMENTS FOR CRNAS, APNS AND APNPS

The Board of Nursing regulates the practice of nursing under Wis. Stat. ch. 441. In 1993 Act 138 the legislature created Wis. Stat. § 441.16 requiring, inter alia, that the BON establish education, training or experience requirements that an RN must satisfy to be an advanced practice nurse (APN) and the additional requirements that an APN must satisfy to qualify for a certificate to issue prescription orders as an advanced practice nurse prescriber (APNP). These BON administrative rules are in Wis. Stat. ch. N 8. The term "advanced" as used in the phrase "advanced practice" in Wis. Stat. § 441.16 is not defined, but evidently refers to the requirement that APNs have education, training or experience in addition to that required for licensure as an RN.

The qualifications of an APN are described in Wis. Adm. Code § N 8.02(1), the BON rule defining an APN:

N 8.02 Definitions. As used in this chapter:

(1) "Advanced practice nurse" means a registered nurse who possesses the following qualifications:

(a) The registered nurse has a current license to practice professional nursing in this state, or has a current license to practice professional nursing in another state which has adopted the nurse licensure compact;

(b) The registered nurse is currently certified by a national certifying body approved by the board as a nurse practitioner, certified nurse-midwife, certified registered nurse anesthetist or clinical nurse specialist; and,

(c) For applicants who receive national certification as a nurse practitioner, certified nurse-midwife, certified registered nurse anesthetist or clinical nurse specialist after July 1, 1998, the registered nurse holds a master's degree in nursing or a related health field granted by a college or university accredited by a regional accrediting agency approved by the board of education in the state in which the college or university is located.

The BON approves certifications by certain national certifying bodies in four areas of advanced practice nursing, including certification by the American Association of Nurse Anesthetists (AANA) as a CRNA.^[26] Certification standards of the AANA require that an applicant for certification hold a license as an RN, complete an accredited nurse anesthesia education program and pass a national certification exam. Nurse anesthesia educational programs are from 24 to 36 months in length, depending on university requirements and are at the master's degree level or higher. The specific admission requirements to anesthesia educational programs and requirements for accreditation of programs are included in the materials submitted by interested parties.^[27]

By definition a CRNA is an APN under Wis. Adm. Code § N 8.02(1). The BON does not separately certify and does not issue a unique certificate or other credential to a CRNA or an APN. The BON relies on the determination of the AANA that an RN meets CRNA certification standards. Only when a CRNA seeks an APNP certificate does the BON receive an application, review the applicant's credentials, issue a certificate, and identify the individual as an APNP on its website.^[28]

Being an APN is a prerequisite for certification as an APNP. In addition to being an APN, under Wis. Adm. Code § N 8.03, an applicant to the BON for an APNP certificate must complete at least 45 contact hours in clinical pharmacology/therapeutics within 3 years preceding the application and pass a jurisprudence examination for advanced practice nurse prescribers. APNPs who are certified by the BON are required to complete an average of at least 8 contact hours per year in clinical pharmacology/therapeutics relevant to the APNP's area of practice. BON rules require APNPs who prescribe independently to maintain malpractice insurance. (Under Wis. Stat. ch. 655, all CRNAs are required to maintain liability insurance.)

If a CRNA obtains certification as an APNP, (becoming a CRNA/APNP) then Wis. Adm. Code § N 8.10(7), requires the CRNA/APNP to work in a collaborative relationship with a physician.

N 8.10(7) Advanced practice nurse prescribers shall work in a collaborative relationship with a physician. The collaborative relationship is a process in which an advanced practice nurse prescriber is working with a physician, in each other's presence when necessary, to deliver health care services within the scope of the practitioner's professional expertise. The advanced practice nurse prescriber and the physician must document this relationship.

Collaboration is defined in Wis. Adm. Code § N 8.02(5):

N 8.02 Definitions. As used in this chapter: (1) . . .

(5) "Collaboration" means a process which involves 2 or more health care professionals working together, in each other's presence when necessary, each contributing one's respective area of expertise to provide more comprehensive care than one alone can offer.

The BON has defined "direct supervision and "general supervision" in Wis. Adm. Code § N 6.02(6) and (7):

(6) "Direct supervision" means immediate availability to continually coordinate, direct and inspect at first hand the practice of another.

(7) "General supervision" means regularly to coordinate, direct and inspect the practice of another.

As defined, "supervision" and "collaboration" are distinct and dissimilar relationships. Under the BON's rule, a CRNA/APNP is required to work in collaborative relationship with a physician, not under the direct or general supervision of a physician.

Petitioner submitted extensive documentation showing that the BON staff or BON members have described the BON position on physician supervision of CRNAs to be that the administration of anesthesia is a delegated medical act that requires the supervision of a physician.^[29] Putting aside the question of the legal consequence of these writings, none of which advanced to become administrative rules, and assuming the BON's position at the time the writings were made was that physician supervision of a CRNA was required, the record shows clearly that this particular policy or interpretation of law for APNPs was changed by an administrative rule. The BON's informal interpretations of CRNA supervision requirements expressed in the WSA Exhibits #5-#39 were replaced by Wis. Adm. Code § N 8.10(7), effective November 1, 2000, requiring APNPs to work in a collaborative relationship with a physician.^[30]

1993 Wisconsin Act 138 (Act 138) requires the BON to grant a certificate to issue prescriptions to an advanced practice nurse who meets education, training and examination requirements established by the Board. The BON adopted Wis. Adm. Code ch. N 8 to implement 1993 Wisconsin Act 138, effective March 1, 1995.^[31] The adopted Wis. Adm. Code § N 8.10 of 1995 is composed of only subsections (1) through (5). As do the current rules, the 1995 rules required in Wis. Adm. Code § N 8.10(5) that "[t]he board shall promote communication and collaboration among advanced practice nurses, physicians and other health care professionals, . . ." The 1995 rules included the definition of collaboration currently in Wis. Adm. Code § N 8.02 (5). However, the 1995 rules in ch. N 8 did not require that APNPs work in a collaborative relationship with a physician.

The BON rule requiring a collaborative relationship resulted from a rulemaking order proposed as Clearinghouse Rule 99-126 (CR99-126). The rule draft published for hearing by the BON proposed creating a new rule, Wis. Adm. Code § N 8.06(1m), prohibiting APNPs from independently ordering laboratory testing except to assist the APNP in issuing a prescription. "Collaboration" was not mentioned in the rule draft.^[32] The rule draft was referred to the Senate Committee on Health, Utilities, and Veterans & Military Affairs on February 10, 2000, for review under Wis. Stat. § 227.19.^[33] The committee voted to recommend that the BON modify the rule by deleting proposed § N 8.06(1m) and creating new sections N 8.10(6) and (7). The BON adopted the modifications proposed by the committee. The effect of the modification was to permit APNPs to order laboratory tests for case management and to require APNPs to work in a documented collaborative relationship with a physician.

The appropriate agency process for changing a standard or a longstanding interpretation of a statute is through rulemaking.^[34] The BON's longstanding interpretation of CRNA supervision requirements was changed by the BON rule in 2000. The fact that the collaboration requirement in Wis. Adm. Code § 8.10(7) resulted from a modification request made by a legislative committee conducting oversight review under Wis. Stat. § 227.19 is unique legislative history that gives weight to the correctness of the BON rule interpreting Wis. Stat. § 441.16.^[35]

THE SCOPE OF PROFESSIONAL NURSING AND CRNA PRACTICE

Whether a CRNA/APNP who administers anesthesia is lawfully practicing within the scope of a credential granted under ch. 441 depends, in part, on the definition of "professional nursing." Under Wis. Stat. § 441.06(2), the holder of a license as an RN is ". . . authorized to practice professional nursing." "Professional nursing" is defined in Wis. Stat. § 441.001(4):

"Professional nursing" means the performance for compensation of any act in the observation or care of the ill, injured, or infirm, or for the maintenance of health or prevention of illness of others, that requires substantial nursing skill, knowledge, or training, or application of nursing principles based on biological, physical, and social sciences. Professional nursing includes any of the following:

- (a) The observation and recording of symptoms and reaction.
- (b) The execution of procedures and techniques in the treatment of the sick under the general or special

supervision or direction of a physician, podiatrist licensed under ch. 448, dentist licensed under ch. 447 or optometrist licensed under ch. 449, or under an order of a person who is licensed to practice medicine, podiatry, dentistry or optometry in another state if the person making the order prepared the order after examining the patient in that other state and directs that the order be carried out in this state.

(c) The execution of general nursing procedures and techniques.

(d) Except as provided in s. 50.04 (2) (b), the supervision of a patient and the supervision and direction of licensed practical nurses and less skilled assistants.

The definition of "professional nursing" in the introductory sentence of Wis. Stat. § 441.001(4) is expansive. The term "any act" is qualified only by acts that are either "in the observation or care of the ill, injured or infirm" or "for maintenance of health or prevention of illness" and require "substantial nursing skill, knowledge, or training, or application of nursing principles based on biological, physical, and social sciences." As more fully discussed below, subsections (a) through (d) set out examples of professional nursing that are included within the general terms of the introductory sentence. These subsections do not describe the whole scope of practice for a professional nurse.

In Act 138 the legislature created Wis. Stat. § 441.16(3), mandating that the BON to,

... promulgate rules necessary to administer this section, including rules for all of the following:

- (a) Establishing the education, training or experience requirements that a registered nurse must satisfy to be an advanced practice nurse. The rules promulgated under this paragraph shall require a registered nurse to have education, training or experience that is in addition to the education, training or experience required for licensure as a registered nurse.
- (am) Establishing the appropriate education, training and examination requirements that an advanced practice nurse must satisfy to qualify for a certificate to issue prescription orders.
- (b) Defining the scope of practice within which an advanced practice nurse may issue prescription orders.
- (c) Specifying the classes of drugs, individual drugs or devices that may not be prescribed by an advanced practice nurse.
- (cm) Specifying the conditions to be met for a registered nurse to do the following:
 - 1. Administer a drug prescribed by an advanced practice nurse who is certified to issue prescription orders.
 - 2. Administer a drug at the direction of an advanced practice nurse who is certified to issue prescription orders.
- (d)

The BON's rules in response to the mandate are brief and broad. Rules adopted under the statute essentially require an APN to be an RN certified by a national certifying body as a nurse practitioner, certified nurse-midwife, certified registered nurse anesthetist or clinical nurse specialist.^[36] An APNP's scope of practice for issuing prescription orders is limited to "... the advanced practice nurse prescriber's areas of competence, as established by his or her education, training or experience."^[37]

The scope of practice for an APN is carved out of the scope of practice defined in § 441.001(4)(intro) rather than from any of the subsections in the definition. This conclusion is evident from the fact that the key statutory characteristics of the APN are the requirement for "... education, training or experience that is in addition to the education, training or experience required for licensure as a registered nurse" and, for APNPs, eligibility to issue prescription orders. The examples of professional nursing in Wis. Stat. § 441.001(4)(a) - (d) do not reflect the advanced practice of an qualified APN holding national certification as a nurse practitioner, certified nurse-midwife, certified registered nurse anesthetist or clinical nurse specialist. The conclusion that the CRNA scope of practice is not within the four subsections of Wis. Stat. § 441.001(4) is evident from the description of anesthesia administration in the Findings of Fact paragraphs 15. - 23., below. The tasks are complex, requiring knowledge, skills and abilities consistent with the additional education, training and experience and national certification required to a CRNA.^[38]

Petitioner maintains that CRNAs who are certified as APNPs may independently prescribe anesthetic drugs without supervision, but may not administer anesthesia without physician supervision.^[39] Petitioner's conclusion is contrary to Wis. Stat. § 441.16(3)(cm)2. which requires the BON to specify the conditions to be met for an RN to "[a]

administer a drug at the direction of an advanced practice nurse who is certified to issue prescription orders.” The statute does not separate the authority to prescribe from the authority to treat and care for a patient.^[40] To the contrary, the statute states that APNP practice includes directing an RN to administer drugs prescribed by the APNP.

Petitioner WSA references a note in the drafting records of the Wisconsin Legislative Reference Bureau relating to 1993 Assembly Bill 756, which was enacted as Act 138. In that note, the drafter expresses an opinion that bill redraft #LRBs0300/3dn,

“ . . . creates a category of RNs called ‘advanced practice nurses’. The only thing that an advanced practice nurse may do that any other registered nurse may not do is qualify for a certificate to issue prescription orders. . . .”^[41]

The WSA references this drafter’s note to support its position that Act 138 simply expanded the prescriptive authority for APNPs and did not affect the scope of professional nursing so as to permit APNPs to administer of anesthesia except as a delegated medical act under physician supervision.^[42] The drafting file in the Legislative Reference Bureau (LRB) for 1993 Assembly Bill 756 also includes a memorandum to the chairperson of the Health Committee from the Government Relations Director of the State Medical Society making four recommendations for modifications to the bill. ^[43] The memorandum describes the nature of the change anticipated from AB 756 to be “a new level of practice,” involving “expanded responsibility” and urges that legislative direction is needed to ensure that “. . . [o]nly the most qualified nurses are able to undertake this dramatically increased responsibility.” Legislative Reference Bureau drafting file records indicates that recommendations in the State Medical Society memorandum were generally incorporated into LRB draft number LRBs0300/5 introduced as Assembly Substitute Amendment 1 to 1993 Assembly Bill 756 and enacted as Act 138.

While Act 138 did not amend the definition of “professional nursing” for APNs, the legislative history of Act 138 and the terms of Wis. Stat. § 441.16, as created by the act, confirm that an APN has a level of responsibility and practice as well as education, training and experience beyond that required of a registered nurse (RN). Statutes are not to be interpreted so as to render the statute a nullity as would an interpretation of Wis. Stat. § 441.16 that requires additional education, training and experience for APNs, but declines to recognize that APNs have an expanded responsibility as a result of meeting the requirements. A plain-language reading that harmonizes Wis. Stat. §§ 441.001 (4) and 441.16 and avoids unreasonable and absurd results permits an APN to engage in areas of professional nursing practice consistent with the APNs advanced education, training and experience that are not available to an RN. An amendment to the definition of “professional nursing” was unnecessary to accomplish this result. In determining the scope of practice of an “advanced practice nurse” the term “advanced” has to be given its ordinary meaning and effect.”^[44]

The broad statutory scope of professional nursing practice is delimited by administrative rule and by the education, training and experience of each credential holder. An RN may not perform services for which the RN is not qualified by education, training or experience.^[45] Wis. Adm. Code § N 8.10(7) requires that an APNP work in a collaborative relationship with a physician. “. . . to deliver health care services within the scope of the practitioner's professional expertise. . . .” (emphasis added). The scope of advanced practice nursing is circumscribed in Wis. Adm. Code § N 8.02(1)(b) by reference to national bodies that certify registered nurses to practice as advanced practice nurses. In Wis. Adm. Code § N 8.06(1) the rules also limit the scope of an APNP’s practice by the restriction that an APNP “may issue only those prescription orders appropriate to the advanced practice nurse prescriber’s areas of competence, as established by his or her education, training or experience.”

The parties dispute whether Wis. Stat. § 441.001(4)(a) through (d) limit the scope of the general definition of “professional nursing” in the first sentence of the definition. If there is textual evidence that the legislature intended a narrow meaning of “includes” to apply, courts have read the word “includes” as a term of limitation or enumeration using the doctrine of *expressio unius est exclusio alterius* (the expression of one thing excludes another.) In statutory definitions, “means” is a term indicating limitation or completeness, whereas “includes” is a term indicating partiality and expansiveness.^[46] “‘Means’ is complete and ‘includes’ is partial.”^[47] The word “includes” appears in the sentence immediately following the general definition of “professional nursing,” in which the word “means” is utilized. Had the legislature intended the subsections of the second sentence of § 441.001(4) to be terms of limitation or exclusivity, it would have used the word “means,” as it did in the first sentence. As enacted, the second sentence is a list of examples of professional nursing. Recent legislative modifications to the statutory definition of “professional nursing” in 2001

Wisconsin Act 107 support the conclusion that subsections 441.001(4)(a) through (d) are "examples" of professional nursing.[48]

Petitioner WSA references an opinion of the California Attorney General on whether a California CRNA may administer regional anesthetics under a standardized procedure. The California Attorney General concluded that,

... a registered nurse and thus a Certified Registered Nurse Anesthetist may lawfully administer a regional anesthetic when ordered by and within the scope of licensure of a physician, dentist, or podiatrist or clinical psychologist but not pursuant to a "standardized procedure" as defined in section 2725.[49]

The WSA urges that the reasoning of the California opinion be used in interpreting the Wisconsin definition of "professional nursing." The California opinion is not appropriate precedent for interpretation of the Wisconsin definition of "professional nursing" because of the specific question considered and the unique history of California law.

Wisconsin law requires CRNAs who are certified as APNPs to work in a documented collaborative relationship with a physician. Unlike the question presented to the California Attorney General, the legal questions presented by the WSA petition do not involve whether a CRNA may practice under "standardized procedures" established in collaboration with health care facilities and providers. Every administration of anesthesia is unique.[50] A collaborative relationship with a physician is more likely to take into account the particular needs of a patient than a standardized procedure.

Section 2725 of the California Nursing Practice Act, the statutory definition of "professional nursing" interpreted in the California opinion, is structured similarly to Wis. Stat. § 441.001(4) in that an introductory paragraph states a general definition, then adds the words "and includes all of the following:" followed by four subsections identifying more specific examples.[51] The California Attorney General points out that section 2726 of the Nursing Practice Act, enacted as part of the same statute which enacted the basic definition of "professional nursing," declares that "this chapter [the Nursing Practice Act] confers no authority to practice medicine or surgery" . . . "[e]xcept as otherwise provided herein." The California opinion also notes that, "[t]he use of nurses to administer anesthetics has had a turbulent history in California law." [52] The turbulent history is summarized in the Attorney General's opinion. Based on the interplay between sections 2725 and 2726 and parts of the "turbulent history" the opinion finds ambiguity in California's definition of professional nursing. A foundation of the California opinion is the application of the doctrine of *ejusdem generis*, a principle of statutory interpretation described by Petitioner WSA as "when general words follow specific words in describing a subject, the general word will be interpreted to include only items of the same type as the specifics listed." [53]

The *ejusdem generis* principle is not applicable to Wis. Stat. § 441.001(4). The Wisconsin Statute defining "professional nursing" does not have a turbulent history and Wis. Stat. ch. 441 does not include a restriction similar to section 2726 of the California Nursing Practice Act. As indicated in the WSA description, the *ejusdem* principle is usually applied to a series of specific words followed by a general word. The definition of "professional nursing" is not such a series. The definition has two parts: "professional nursing means" followed by a general descriptor; then "professional nursing includes" followed by more specific descriptors. Restricting the expansive definition of "professional nursing" to only acts of the same type as those described in subsections (a) through (d) of Wis. Stat. § 441.001(4) directly contradicts the expressed legislative policy in 1993 Wisconsin Act 138, confirmed in the legislative review of the rules in Wis. Adm. Code ch N 8, to provide for an area of advanced practice nursing requiring ". . . education, training or experience that is in addition to the education, training or experience required for licensure as a registered nurse." [54]

RELATED LAWS

The fact that that professional nursing includes the administration of anesthesia is evident in laws related to CRNA practice. In 1975 the legislature, perceiving a crisis in health care liability coverage, enacted Chapter 37, Laws of 1975, creating ch. 655 of the Statutes.[55] Among other things, ch. 655 requires physicians, nurse anesthetists and hospitals to participate in a plan of healthcare liability coverage under rules of the Commissioner of Insurance. The plan was, when enacted, and still is, mandatory for state "health care providers" now defined by Wis. Stat. § 655.001(8):

"Health care provider" means a medical or osteopathic physician licensed under ch. 448, a nurse

anesthetist licensed under ch. 441 or a hospital as defined by s. 140.24 (1) (a) and (c), but excluding those facilities exempted by s. 140.29 (3).

In Wisconsin, under Wis. Stat. ch. 655, nurse anesthetists are classified the same as physicians and differently from other health care professionals. [56] Although changes have been made to Wis. Stat. ch. 655 since 1975, the chapter still provides the exclusive procedure for malpractice claims brought against "health care providers" *i.e.* physicians, nurse anesthetists, hospitals and their related organizations. [57] (Under present Wis. Stat. § 655.005, malpractice claims against employees of health care providers are also subject to ch. 655. [58])

The fact that CRNAs have a unique scope of practice and that CRNAs are significant providers of anesthesia services in Wisconsin is evident in Wis. Stat. ch. 655, which has provided for a healthcare liability plan that is mandatory for physicians and CRNAs since 1975.

The Wisconsin Department of Health and Family Services (DHFS) administers rules in Wis. Adm. Code ch. 124 governing standards for the operation of hospitals under the "Hospital Regulation and Approval Act." [59] The rules are intended to promote safe and adequate care and treatment of patients in hospitals. Among other things the rules require that hospitals have policies and procedures relating to the staffing and functions of different services provided by hospitals. The hospital rules regulating surgery and anesthesia services identify nurse anesthetists as alternative healthcare providers to physicians and anesthesiologists. The surgery policies rule, for example, requires that,

4. There shall be adequate provisions for immediate postoperative care. A patient may be directly discharged from post-anesthetic recovery status only by an anesthesiologist, another qualified physician or a registered nurse anesthetist. [60]

The DHFS rule for anesthesia use requirements in hospitals includes the following:

3. If anesthetics are not administered by a qualified anesthesiologist, they shall be administered by a physician anesthetist, dental anesthetist, podiatrist or a registered nurse anesthetist, under supervision as defined by medical staff policy. The hospital, on recommendation of the medical staff, shall designate persons qualified to administer anesthetics and shall determine what each person is qualified to do.

4. The services provided by podiatrist, dentist or nurse anesthetists shall be documented, as well as the supervision that each receives.

5. If a general anesthetic is used and a physician is not a member of the operating team, a physician shall be immediately available in the hospital or an adjacent clinic to assist in emergency situations. [61]

These rules not only support the conclusion that CRNAs are involved in administration of anesthesia in hospitals, but are structured to permit a CRNA/APNP to practice without physician supervision. Under sub. 5. of these rules, a CRNA may administer anesthesia even if a physician is not a member of the operating team if the medical staff designates the CRNA as qualified. The record includes an affidavit of Irene Temple, an attorney employed by the DHFS, who has responsibility to advise the Department's Bureau of Quality Assurance regarding the interpretation of the Department's rules relating to the regulation of hospitals. With respect to supervision, Irene Temple's affidavit includes the statement that,

Section HFS 124(3) does not specify the extent of supervision of anesthetists who are not anesthesiologists. Under the rule, the extent of supervision required, if any, is to be determined by the hospital through its medical staff policies.

These rules identify a CRNA as a provider of anesthesia service in a hospital and authorize assignment of substantial responsibility to the CRNA.

LIMITATIONS ON PODIATRISTS

Under Wis. Stat. § 448.60(4) "Podiatry" or "podiatric medicine and surgery" is defined to mean,

... that branch or system of the practice of medicine and surgery that involves treating the sick which is limited to conditions affecting the foot and ankle, but does not include the use of a general anesthetic unless administered by or under the direction of a person licensed to practice medicine and surgery under subch. II.

Through an affidavit of its chairperson, Dr. Lisa Reinicke, the PACB stated its position that CRNAs routinely administer general anesthesia to podiatric surgical patients without the supervision of a physician, especially in rural hospitals.

According to Dr. Reinicke, requiring CRNAs to be supervised by a physician would likely impinge upon patient access to podiatric surgical care.

As described above, a CRNA/APNP within an exception to the physician licensing statute. The statute regulating podiatrists contains a similar exception. Under Wis. Stat. § 448.62(1) the statute requiring a podiatry license does not apply to “[a] person lawfully practicing within the scope of a license, permit, registration or certification granted by this state or the federal government.” Consequently, the statutory definition of podiatry does not restrict the lawful practice of a CRNA/APNP.

Rules of the BON mandate that a CRNA/APNP work in a collaborative relationship with a physician. Apart from the required collaborative relationship, a CRNA/APNP practices independently, not under delegated authority from a physician or podiatrist. Of course, both the podiatrist and the CRNA/APNP are required to comply with the appropriate rules of the DHFS governing surgical and anesthesia services which may require that a physician be present or immediately available. For CRNAs not APNP certified, compliance with Wis. Stat. § 448.03(1) requires that the administration of anesthesia by the CRNA be directed, supervised and inspected by a physician who has the power to direct, decide and oversee the patient services. Use of CRNAs to administer general anesthesia appears to be a matter of joint interest between the MEB and the PACB that may warrant discussion under the procedure in Wis. Stat. § 15.085(3)(b)[62].

CONCLUSION

While material facts relating to the administration of anesthesia are generally agreed to by the parties, Petitioner WSA has not shown that it is entitled to judgment on its motion as a matter of law. The conclusions of law proposed by the petitioner relating to physician supervision when a CRNA administers anesthesia are not fully consistent with established state law. There is an overlap in the health care practice of physicians and CRNAs. The law that requires a license as a physician to practice medicine and surgery exempts persons lawfully practicing within the scope of a certificate to practice professional nursing issued by the BON. Administration of anesthesia is included within the statutory definition of “professional nursing.” A CRNA may lawfully administer anesthesia without physician supervision under the exemption if certified as an APNP and if the CRNA maintains and documents a collaborative relationship with a physician.

A CRNA who is not certified as an APNP is not subject to the BON rule requiring a collaborative relationship with a physician and does not qualify for the same exemption from the physician licensing requirement as a CRNA/APNP. Longstanding policies and administrative rules of the BON require physician supervision of administration of anesthesia by a CRNA who is not certified as an APNP.

The appropriate order is to deny petitioners motion for summary judgment.

The proposed order also dismisses the Petition for a Declaratory Ruling because the Medical Board’s decision on Petitioner’s summary judgment motion resolves the controversies presented by the petition. The issues raised by the Petition are essentially questions of law. Additional facts developed from a contested hearing would not change the legal analysis of the central issues. None of the parties has a right to a declaratory ruling. There is no necessity for a declaratory ruling to permit physicians and CRNAs to avoid unprofessional conduct or malpractice findings as was contended by the WSA. Hospitals and insurers may rely on Wis. Stat. chs. 441 and 448 and BON rules to accept the legitimacy of anesthesia administration by CRNA/APNPs working in a collaborative relationship with a physician.

Citing Act 138 and *Sermchief v. Gonzales*, 660 S.W.2d 683 (Mo. 1983), the BON and the WANA argue that the practice of professional nursing has evolved because of changes in healthcare technology, delivery systems, education and training. They contend that the delivery of health care is now provided by a team of professionals who work interdependently in collaborative relationships rather than traditional hierarchical or supervisory models. Although there is a background of change in Wisconsin law relating to the scope of professional nursing consistent with a *Sermchief* type of analysis, the petition in this case presents an issue that is determined directly by reference to statute and administrative rule.

The Medical Examining Board or the Board of Nursing may determine that the petition has raised public policy issues that need further attention. If so, administrative rulemaking seems preferable to the declaratory ruling process for these quasi-legislative tasks because rulemaking affords opportunity for a hearing to receive public comments and

results in a published rule.[63]

The conclusion in this decision that a CRNA who is certified as an APNP is required to work in collaboration with a physician, rather than under physician supervision, meets public policy criteria of occupational regulation. A CRNA/APNP may not perform services for which he or she is not qualified by education, training or experience. The state assures the public of the competence of the CRNA/APNP by a regulatory system that includes defined education and training requirements, an examination, experience and credentialing as an RN, professional practice standards, mandated liability insurance coverage, regulation by a related state agency, and mandated collaboration with a physician.

FINDINGS OF FACT

The Findings of Fact, below, are based on the proposals and responses of the petitioner and interested parties that are in the record. [64]

BASIC NATURE OF ANESTHESIA PRACTICE

1. Anesthesiology is a healthcare specialty concerned with the pharmacological, physiological and clinical basis of anesthesia and related fields, including resuscitation, intensive care, respiratory care, and acute and chronic pain. The practice of anesthesiology is dedicated primarily to the relief of pain and total care of the patient before, during and after surgical and obstetrical procedures.
2. The practice of anesthesiology includes:
 - a. The medical management of patients who are rendered unconscious and/or insensible to pain and emotional stress during surgical, obstetrical and certain other medical procedures. This includes pre-operative, intra-operative and post-operative evaluation and treatment of these patients;
 - b. The protection of life functions and vital organs (e.g., brain, heart, lungs, kidneys, liver) under the anesthesia and the stress of surgical and other medical procedures;
 - c. The management of airway access (both routine and difficult);
 - d. The management of problems regarding pain relief;
 - e. The management of cardiopulmonary resuscitation;
 - f. The management of routine and potential problems in pulmonary care; and,
 - g. The management of critically ill patients in special care units.
3. The practice of anesthesia requires the exercise of judgment concerning:
 - a. Selection of the appropriate drugs for anesthesia and for treatment of a patient's other medical conditions while under anesthesia;[65]
 - b. Determination that the patient is fit to undergo anesthesia;
 - c. Administration of the anesthetic, resuscitative, and related drugs during the course of the procedure and adjusting the mixture of drugs, oxygen, and other gases to keep the patient alive while anesthetized;
 - d. Monitoring the patient throughout the procedure; and,
 - e. Intervening in emergencies, such as a heart attack or an asthma attack, that a patient may suffer while under anesthesia.
4. There are different kinds of anesthesia. "General anesthesia" is the administration of drugs which causes loss of consciousness as the result of which the patient is unable to make meaningful responses. "Moderate" is the administration of a drug to induce that state of consciousness in a patient which allows the patient to tolerate unpleasant medical procedures without losing defensive reflexes, adequate cardio and the ability to respond purposefully to verbal command or to tactile stimulation if verbal response is not possible as, for example, in the case of a small child or a deaf person. "Regional anesthesia" is the administration of anesthetic agents to a patient to interrupt pain nerve impulses without loss of consciousness. It includes epidural, caudal, spinal, brachial plexus, and peripheral nerve anesthesia.
5. Notwithstanding great reductions in mortality rates from anesthesia over the past several years, the administration of anesthesia is an inherently risky process with significant potential for morbidity or mortality.

PROVIDERS OF ANESTHESIA CARE

6. Providers of anesthesia care may be divided into two basic groups: physicians specially trained in anesthesiology, and non-physician providers. The first group includes anesthesiologists, anesthesiology residents (a physician who is presently in an approved anesthesiology residency program), and other physicians with particularized training in the specialty. The second group includes CRNAs and Anesthesiology Assistants (AAs). An anesthesiologist working with either an anesthesiology resident, a CRNA, or an AA is referred to as the "Anesthesia Care Team." Others who have patient care functions during the perioperative period include post-anesthesia nurses, critical care nurses, respiratory therapists, and support personnel (anesthesia technologists and technicians, anesthesia aides, blood gas technicians, respiratory technicians, and monitoring technicians).

7. An anesthesiologist is a physician who specializes in the practice of anesthesia. Anesthesiologists function as "perioperative" physicians, meaning that the anesthesiologist is usually the single medical doctor responsible for providing comprehensive care to a patient at all stages of a surgical procedure. This includes medically evaluating the patient before the procedure, consulting with the surgical team, providing pain control, amnesia, and life support during the procedure, supervising post-operative care, and determining when a patient may safely be discharged.

EDUCATION AND TRAINING OF ANESTHESIOLOGISTS

8. Anesthesiologists must complete twelve years of formal education:

- a. Four years of science - intensive pre undergraduate education;
- b. Four years of medical school in which the individual gains knowledge of the fundamental science of the human condition (biochemistry, biophysics, anatomy, pharmacology, physiology, and pathophysiology of disease states) and receives extensive clinical instruction and experience in medical diagnosis and therapy; and,
- c. Four years of residency training that includes one year of clinical medicine and three years of clinical anesthesiology.
- d. Anesthesiologists receive extended training in pharmacokinetics, which is the quantitative study of the action of drugs in the body over a period of time including absorption, distribution, localization, biotransformation, and excretion. Knowledge of these processes is used to match the appropriate medications to a particular patient. Many anesthesiologists also elect to receive training in subspecialties such as pediatric anesthesia, critical care medicine, cardiac anesthesia, and pain management.

9. Anesthesiologists by virtue of their education and training are qualified to make medical judgments with regard to all aspects of the administration of anesthesia including, without limitation, emergency intervention and rescue from complications.

EDUCATION AND TRAINING OF CRNAS

10. CRNAs are registered nurses who have attended an accredited nurse anesthesia education program and, upon graduation therefrom, passed a national certification exam and thereby obtained national certification as a CRNA.

- a. A certified registered nurse anesthetist must graduate from a nurse anesthesia educational program accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs or its predecessors, and pass the certification examination administered by the Council on Certification of Nurse Anesthetists or its predecessors.
- b. There are more than 80 nurse anesthesia educational programs in the United States, all affiliated with, or operated by universities. Approximately one-half of those programs are located in schools of nursing or schools of health sciences or other appropriate graduate schools.
- c. The programs offered for nurse anesthesia education range from 24 to 36 months in length, depending on university requirements and all are at the master's degree level or higher.
- d. Accredited nurse anesthesia education programs provide graduate level science courses along with clinical anesthesia to prepare the student to become competent nurse anesthesia providers. The science curriculum of graduate nurse anesthesia programs includes the following:
 - i) A minimum of 135 hours in Advanced Anatomy, Physiology and Pathophysiology.
 - ii) A minimum of 90 hours in Advanced Pharmacology.
 - iii) A minimum of 45 hours of Chemistry and Physics related to anesthesia.
 - iv) The minimum requirement of 90 hours of courses in anesthesia practice provides content such as induction, maintenance, and emergence of anesthesia, airway management, anesthesia pharmacology; and anesthesia for special patient populations such as obstetrics, geriatrics and pediatrics.
 - v) Many accredited nurse anesthesia education programs provide scientific inquiry and statistics as well as active participation in student and faculty-sponsored research and clinical residencies

which allow students to learn anesthesia techniques, test theory and apply knowledge to clinical problems.

vi) Nurse anesthesia educational programs provide an average of 1,595 hours of clinical experience for each student.

11. The general requirements for admission into a nurse anesthesia education program are:

- a. A degree in nursing;
- b. A license as a registered nurse; and,
- c. A minimum of one year of acute care nursing experience.

12. In most instances, in Wisconsin, anesthesia care is typically furnished by an anesthesiologist or administered by a CRNA, AA, or anesthesiology resident, in each case acting under the direction of an anesthesiologist. The following paragraphs describe typical anesthesia care where the anesthesia care is performed by the anesthesiologist alone or by a CRNA, AA, or anesthesiology resident that is being directed by the anesthesiologist.

- a. CRNAs who have successfully completed an accredited nurse anesthesia program have the education and training necessary to successfully and independently administer anesthesia.^[66]
- b. Under Wisconsin law, a CRNA who is certified as an APNP may administer anesthesia without the supervision of a physician, but must work in a collaborative relationship with a physician.
- c. Under Wisconsin law, a CRNA who is not certified as APNP may administer anesthesia only as directed, supervised and inspected by a physician.

13. The specific tasks involved in anesthesia care, which are described in the following paragraphs, are generally performed by: (1) an anesthesiologist; or (2) a CRNA, AA, or anesthesiology resident^[67]. The particular tasks that the anesthesiologist reserves for himself/herself to perform are variable by the institution, by the normal practice of each anesthesiologist in that institution, and by the particular circumstances in each instance of anesthesia care. The particular tasks assigned to each CRNA, AA, or anesthesiology resident are also variable by the institution, by the normal practice of each anesthesiologist in that institution, and by the particular circumstances in each instance of anesthesia care.

14. Typically, a patient goes to a primary care physician for a routine check up or with a medical complaint. If the physician sees the potential need for a surgical procedure, the physician refers the patient to a surgeon. The surgeon then reviews the patient record, examines the patient and determines the following: (1) if a surgical procedure is indeed needed; (2) the type of surgical procedure needed; and, (3) the benefits and risks of the procedure based on the procedure and the patient's health. The surgeon then provides the patient with information on the procedure and the benefits and risks of the procedure. If a procedure is deemed necessary and the patient consents to the procedure, the patient is then scheduled for the procedure by the surgeon or his/her office personnel.

15. A patient who will receive anesthesia in connection with such procedure typically receives the following pre-operative care:

a. At some point following the initial appointment with the surgeon, and prior to the procedure, the patient receives an anesthetic preoperative assessment work-up. This consists of a careful and concise review of the patient's medical record and pertinent labs and tests. Included in the review are details on patient current history of medical illness or injury, past medical history, past surgical and anesthetic history (including complications or adverse reactions that occurred), review of patient's blood relative anesthetic complications, review of organ systems and organ pathology with the potential influence on the management of anesthesia (neurological, cardiovascular, pulmonary, gastrointestinal, renal, hepatic, musculoskeletal, endocrine, gynecological, urological, and hematological), review of current vital signs (blood pressure, heart rate, temperature, respirations), review of allergic reactions (medication, latex, food) and current drug regimen, notation of the time of last food or fluid consumption as part of the analysis of risk of aspiration, and review of laboratory data and radiological studies that could influence the management of anesthesia. When conducting such a review, it is extremely important to be able to recognize certain symptoms of illness or infirmity (sometimes subtle), which may have serious consequences or lead to complications when the patient is exposed to an anesthetic. Examples of instances in which recognition of subtle symptoms are necessary include patients who may have undiagnosed sleep apnea and patients who may have undiagnosed cardiac ischemia. If such symptoms are not recognized and diagnosed prior to the procedure, the administration of anesthesia could have serious consequences. In the case of an undiagnosed sleep apnea, there could be issues with airway placement, ventilation in the operating room, and post-operative ventilation.

a.1. This anesthetic preoperative review may be performed by the anesthesiologist assigned to the procedure (if known ahead of time), or it may be done prior to the time that the anesthesia assignments are made. When the anesthetic preoperative review is done prior to the time that anesthesia personnel assignments

are made for a procedure, it may be performed by: (1) another anesthesiologist; (2) a CRNA; (3) an AA; (4) an anesthesiology resident; or (5) a nurse working in the anesthesia preoperative work clinic or surgical clinic, or assigned to perform daily anesthetic preoperative work-ups. Typically, there is a department standardized preoperative sheet, which contains lists of desired information and tests to be collected from the patient record, that is filled out. Once assignments are made, the preoperative anesthesia work is always thoroughly reviewed by the anesthesiologist when an anesthesiologist is in charge of the anesthetic.[68]

a.2. Next a physical exam of the patient is performed, focusing on cardiac and pulmonary systems, organ systems which the surgery involves, organ systems that the patient expresses concern about, and organ systems of concern following patient chart review and history. The patient airway is then examined for signs of potential difficulty with airway management or intubation (placement of a breathing tube). This physical exam and airway exam are usually performed by both the staff anesthesiologist responsible for the anesthetic plan, delivery, and postoperative care of the patient, and by the non-physician provider (CRNA, AA) or anesthesiology resident, if also assigned to deliver the anesthetic.

b. Following review of history, review of surgical procedure, and physical exam, an anesthetic management plan is developed consisting of the decision on type of anesthetic to be delivered (general, regional: spinal or epidural, peripheral nerve block, monitored anesthesia care), plan for airway management, determination of invasive vascular catheters to be placed (peripheral I.V., arterial line, central venous line), and determination of monitors needed including standard monitors (electrocardiogram, non-invasive blood pressure, pulse oximetry, capnography, temperature) and invasive monitors (arterial blood pressure, central venous pressure, and pulmonary artery catheter allowing for the measurement of right atrial, right ventricular, left atrial, and cardiac output measurements). Consideration of other monitors/tests needed for the surgical procedure (EEG, somatosensory evoked potentials) is given, as these may also influence choice of anesthetic.

c. The anesthesiologist and other Anesthesia Care Team members (CRNA, AA, or anesthesiology resident) talk to the patient and give the patient the information regarding: (1) the anesthetic plan to be delivered; (2) the monitoring of the patient that will occur during the procedure, including any invasive lines that will be placed for monitoring purposes; and (3) the benefits and risks of the particular type of anesthesia and monitors and invasive lines that will be used.[69]

d. The anesthesiologist or other involved physician signs orders for any pre-operative drugs that will be given to the patient prior to the procedure. A CRNA with prescriptive authority may also prescribe pre-operative drugs pursuant to the CRNA's own DEA number and prescriptive authority.

e. Following approval, the anesthetic plan is then carried out by the anesthesiologist if working alone, or by the CRNA, AA, or anesthesiology resident.[70]

16. The dispensing of anesthesia is usually performed by an anesthesiologist, CRNA, AA, or anesthesiology resident. The anesthesiologist, CRNA, AA, or anesthesiology resident go to the pharmacy and check out the narcotics that were prescribed pursuant to the anesthesia plan. The anesthesiologist, CRNA, AA, or anesthesiology resident will then place the medications in the operating room. In addition, there is typically a cart in the operating room that has the non-narcotic standard medications available.

17. Shortly before the administration of anesthesia, the anesthesiologist, CRNA, AA, or anesthesiology resident inspects and sets-up the anesthesia machine. The anesthesia machine includes a source of compressed gases, a breathing system, a ventilator, anesthetic vaporizers, and flowmeters to deliver known flows and concentrations of anesthetic gases into the breathing system. Suction, monitors, drugs, and airway equipment are also set-up in the operating room.

18. As with the other tasks involved in anesthesia care, the tasks involved in the actual administration of anesthesia are performed by (1) the anesthesiologist; or (2) a CRNA, AA, or anesthesiology resident.[71] When the CRNA, AA, or anesthesiology resident acts under the direction of the anesthesiologist, an anesthesiologist is either in the room of the procedure or is available to reach the room of the procedure within minutes of being paged to the room. Depending on the type of anesthesia involved, the administration of anesthesia typically proceeds as follows:

a. General anesthesia.

i. A peripheral I.V. catheter is usually put in place (with the exception of the pediatric patient who may be put to sleep via mask induction), and in many instances, a sedative, anxiolytic (anxiety reducing medication), and/or amnestic (medicine decreasing ability to remember) is given to the patient. The patient is then transported to the operating room and placed on the operating room table. All non-invasive monitors are placed, and in some instances, when needed to monitor the patient for anesthetic induction (delivery of the anesthetic to achieve an unconscious state) invasive monitors are also placed (i.e. arterial line or central venous line).

ii. The patient's vital signs are continuously monitored and recorded on the anesthetic record every five minutes, or more frequently as needed. Blood pressure and heart rate are usually maintained at the patient's normal baseline value, however, for some cases it is preferred that the patient's blood pressure be maintained

slightly hypertensive (above normal) to maintain cerebral (brain) perfusion pressure, or slightly hypotensive (below normal) to decrease the amount of bleeding. Intravenous fluid is delivered at a rate determined by the patient's hourly normal requirement, and the amount needed for replacement of blood and body fluid lost during the procedure. Loss of blood, plasma, and coagulation factors are monitored during the procedure, and products are replaced as needed. Patient temperature is maintained at a normal level.

iii. The patient is pre-oxygenated with a mask and breathing system containing 100% oxygen for approximately 5-6 minutes. If the patient is not at risk for aspiration or potential difficult airway, I.V. induction of anesthesia occurs with the delivery of a hypnotic drug. This produces a rapid onset of unconsciousness. Once it is determined that the patient can be ventilated by mask, an intravenous paralytic drug is given. This causes muscle paralysis that facilitates direct laryngoscopy for intubation of the trachea (placement of a breathing tube in the trachea). A breathing tube is then placed into the patient's trachea. The placement of the breathing tube in the patient's trachea is then confirmed by the presence of end tidal carbon dioxide (capnography showing the patient exhalation of carbon dioxide), and patient breath sounds on auscultation (listening) of the lungs.

iv. If the patient is at risk for aspiration, a "rapid sequence induction" is performed. In a rapid sequence induction, the patient is given a hypnotic that is immediately followed by a dose of a very rapid acting paralytic drug. Cricoid pressure (pressure held over the cricoid cartilage on the neck which occludes the esophagus) is maintained on the patient's neck and esophagus until the breathing tube is inserted, and placement in the trachea is confirmed.

v. If the patient presents a potentially difficult airway (i.e. it is unlikely that a breathing tube can be placed by routine direct laryngoscopy), a fiberoptic scope may be used for placement of the breathing tube. If its use is anticipated, this equipment is set up in advance of patient induction of anesthesia. Following placement of the airway breathing tube, the patient is usually placed on the ventilator, which is set to deliver an adequate volume of breathing gases and oxygen at a specific rate. The patient is maintained in a pain-free asleep state with the continued delivery of anesthetic and narcotics. Muscle paralysis is maintained and monitored as needed for the surgical procedure. Antibiotics are administered to prevent infection prior to the beginning of the procedure, and re-dosed as needed.

vi. Following the end of procedure, in most instances, the patient is allowed to awaken. Delivery of the anesthetic is discontinued, and the patient is extubated (breathing tube removed) when it is determined that he or she is sufficiently awake with adequate airway reflexes to prevent aspiration. The patient is then transported either to the post-anesthesia care unit (PACU) or the intensive care unit (ICU). The patient is placed on appropriate monitors and vital signs are taken. Report of the patient's pre-operative history, and intraoperative history and management is given to the attending nurse. Post-operative orders for blood pressure management, pain management, fluid management, and postoperative nausea management are written.

b. Moderate sedation (monitored anesthesia care - "MAC").

i. The administration of moderate sedation (MAC) includes the steps outlined in section (i) of the above description of the administration of general anesthesia.

ii. The administration of moderate sedation (MAC) includes the steps outlined in section (ii) of the above description of the administration of general anesthesia.

iii. The patient is sedated with medications (usually a mix of anxiolytic, amnestic agents, hypnotic agents and narcotics). Care is exercised to not over sedate the patient to the point that supplemental respiration needs to be initiated. Supplemental oxygen is delivered as needed, usually by nasal cannula (tubing placed in the nose to deliver oxygen). The patient's respirations are constantly monitored and should the patient become over-sedated, respirations are supported.

c. Administration of regional anesthesia.

i. The administration of regional anesthesia includes the steps outlined in section (i) of the above description of the administration of general anesthesia.

ii. The administration of regional anesthesia includes the steps outlined in section (ii) of the above description of the administration of general anesthesia.

iii. Spinal or epidural catheter/medication is placed in the preoperative area, block room, or the operating room prior to surgery. In all instances, sterile technique is applied. Spinal, epidural and caudal blocks are referred to as regional or conduction block anesthesia. A spinal block is produced by the injection of a local anesthetic solution into the lumbar subarachnoid space (the space containing spinal fluid). An epidural block is produced with the injection of a local anesthetic into the epidural space usually at the lumbar or thoracic level that allows for a spread to get pain relief coverage in the area of surgical incision. A caudal block is performed by placing local anesthetic in the epidural space via a needle introduced through the sacral hiatus. For placement of spinal local anesthetic, the patient is usually placed in the sitting or lateral position. The vertebral level in which

the anesthetic is to be placed is determined. The patient's area of skin over the vertebral level to be injected is sterilely prepped with an antiseptic solution and draped. A small amount of subcutaneous local anesthetic is injected, to allow for the placement of the spinal needle. A spinal needle is placed between two spinous processes, and advanced through the supraspinous ligament, ligamentum flavum and dural matter. The needle is advanced until cerebral spinal fluid flows from the site of injection. This signals that the subarachnoid space has been entered, and the local anesthetic is then injected. After injection, the needle is removed. The patient is then laid down in the supine position. The patient's level of anesthetic (numbness) is assessed with pinprick, or ability to feel cold. The patient (if not in the operating room) is then transported to the operating room and placed on the operating room table. All non-invasive monitors are placed, and in some instances, invasive monitors are also placed.

iv. For placement of epidural local anesthetic, or epidural catheter for the continuous delivery of local anesthetic, the patient is usually placed in the sitting or lateral position. The vertebral level in which the anesthetic is to be placed is determined. The patient's area of skin over the vertebral level to be injected is sterilely prepped with an antiseptic solution and draped. A small amount of subcutaneous local anesthetic is injected, to allow for the placement of the epidural needle. A common method for identifying the epidural space is the "loss of resistance" technique. An epidural needle is placed between two spinous processes, and advanced into the supraspinous ligament. After advancement into the ligamentum flavum, a glass syringe filled with air or sterile saline is attached. If the needle is correctly placed in the ligament, it will be difficult to inject the air or saline, and when the plunger is lightly pushed, it will "bounce back". The needle is advanced with continuous pushing on the plunger, until the air/saline has a sudden loss of resistance, signaling entrance into the epidural space. Local anesthetic can then be injected, or at this point, a catheter can be introduced through the needle, into the epidural space. The needle is then removed. The patient is then laid down supine. The patient's level of anesthetic (numbness) is assessed with pinprick, or ability to feel cold ice. The patient (if not in the operating room) is then transported to the operating room and placed on the operating room table. All non-invasive monitors are placed, and in some instances, invasive monitors are also placed. The patient is sedated as in the case of moderate sedation as described above.

v. The administration of regional anesthesia includes the steps outlined in section (iii) of the above description of the administration of moderate sedation (MAC).

vi. Following the end of procedure, post-operative orders for blood pressure management, pain management, fluid management, and post-operative nausea management, are issued.^[72] Possible complications of spinal block include hypotension (due to sympathetic nerve blockade and resulting venous pooling (widening of the veins which then hold more blood volume) and decreased venous return (decrease in blood return to the heart), or block of cardioaccelerator fibers (nerves that cause heart rate to increase) contributing to bradycardia (slow heart rate) and decreased cardiac output, post spinal headache, high spinal (which can result in inability to breathe or unconsciousness), nausea and vomiting, backache, or neurological sequelae/injury. Complications of epidural block are similar to those of spinal block, with the added risk of accidental dural puncture resulting in leak of spinal fluid and post dural puncture headache.

d. Administration of a peripheral nerve block.

i. The administration of a peripheral nerve block includes the steps outlined in section (i) of the above description of the administration of general anesthesia.

ii. The administration of a peripheral nerve block includes the steps outlined in section (ii) of the above description of the administration of general anesthesia.

iii. A peripheral nerve block is placed by locating the peripheral nerve supplying the area involved with the surgery, sterile prep and drape of the area in which the block is to be placed. Delivery of an adequate amount of local anesthetic is made via a sterile syringe and needle to the area surrounding the peripheral nerve to be anesthetized. Location of the nerve is often performed with the use of an electrical peripheral nerve stimulator, or ultrasound. Examples of peripheral nerve blocks are median, radial, or ulnar nerve blocks for hand surgery, axillary nerve block for arm and hand surgery, femoral sciatic nerve blocks for knee surgery or amputation of the lower extremity, ankle block for foot or toe surgery. The patient's respirations are constantly monitored, and should they become over sedated, respirations are supported.

iv. The administration of a peripheral nerve block includes the steps outlined in section (iii) of the above description of the administration of moderate sedation (MAC).

19. The monitoring of general anesthesia, moderate sedation (MAC), regional anesthesia, or peripheral nerve block during a procedure includes the following:

a. The patient's oxygenation is continually evaluated. Methods of continual evaluation of the patient's oxygenation include the following:

- i. Inspired gas (i.e. delivering gas to a patient so that the patient has an adequate level of oxygen). During every administration of general anesthesia using an anesthesia machine, the concentration of oxygen in the patient breathing system is measured by an oxygen analyzer with a low oxygen concentration limit alarm in use.
 - ii. Blood oxygenation: During all anesthetics, a quantitative method of assessing oxygenation such as pulse oximetry (a device that shines two frequencies of light through skin and measures the percentage of hemoglobin carrying oxygen) is employed. When the pulse oximeter is utilized, the variable pitch pulse tone and the low threshold alarm is audible. Adequate illumination and exposure of the patient are necessary to assess color.
 - b. The patient's ventilation is continually evaluated. Methods of continual evaluation of the patient's ventilation (ensuring the provision of both oxygen and carbon dioxide to a patient) include the following:
 - i. The patient's qualitative clinical signs are monitored such as chest excursion (the rising and falling of the chest), observation of the reservoir breathing bag (if a patient is breathing on his or her own, operating room personnel can observe the bag and see it move as a patient breathes) and auscultation (listening with a stethoscope to each side of the chest) of breath sounds. Continual monitoring for the presence of expired carbon dioxide is performed unless invalidated by the nature of the patient, procedure or equipment. Quantitative monitoring of the volume of expired gas is often conducted.
 - ii. When an endotracheal tube or laryngeal mask is inserted, its correct positioning is verified by clinical assessment and by identification of carbon dioxide in the expired gas. Continual end-tidal carbon dioxide analysis (amount of carbon dioxide that is expelled by the patient), in use from the time of endotracheal tube/laryngeal mask placement until extubation/removal or initiating transfer to a postoperative care location, is performed using a quantitative method such as capnography (a machine that measures carbon dioxide levels). When capnography is utilized, the end tidal carbon dioxide alarm is audible when necessary.
 - iii. When ventilation is controlled by a mechanical ventilator, a device is continuously used that is capable of detecting disconnection of components of the breathing system. The device gives an audible signal when its alarm threshold is exceeded.
 - iv. During regional anesthesia and monitored anesthesia care, the adequacy of ventilation is evaluated by continual observation of qualitative clinical signs (such as chest wall movement and pulse oximetry readings), and/or monitoring for the presence of exhaled carbon dioxide.
 - c. The patient's circulatory function is continually evaluated. Methods of continual evaluation of the patient's circulatory function include the following:
 - i. Every patient receiving anesthesia is monitored with an electrocardiogram (machine that monitors for heart rate, heart rhythm, and heart ischemia), which continuously monitors heart function from the time that anesthesia is first administered until the patient leaves the operating room;
 - ii. Every patient receiving anesthesia has his or her blood pressure and oxygen saturation monitored and evaluated every five minutes during the administration of anesthesia; and
 - iii. Every patient receiving general anesthesia has his or her circulatory function continually evaluated during the administration of anesthesia by one or more of the following: taking a pulse, listening to heart sounds, monitoring a tracing of intra-arterial pressure, or pulse oximetry.
 - d. There must be the capability to continually monitor a patient's body temperature.
 - e. Additional invasive monitoring (i.e. central venous line or arterial line) may be used on the patient.^[73]
 - f. If a general anesthetic is used and a physician is not a member of the operating team, a physician shall be immediately available in the hospital or an adjacent clinic to assist in emergency situations.^[74]
20. Following completion of the administration of anesthesia, the following care is afforded the patient:
- a. The patient is evaluated.
 - b. The care of the patient is directly transferred to a qualified health care professional in the post-anesthesia care unit (PACU)/recovery room or the intensive care unit (ICU).^[75] Such professional must be capable of monitoring the patient's vital signs. The professional must also be capable of assessing the patient for pain, nausea/vomiting, and complications that can arise from surgery and anesthesia (i.e. hypertension, hypoxia, etc.). Should complications occur, the professional must immediately notify a physician. Such individual must also be trained to administer medications as required for analgesia, nausea/vomiting, or other indications.
 - c. Monitoring in the recovery area includes pulse oximetry, non-invasive blood pressure monitoring, heart rate monitoring, and invasive monitoring (arterial line, central venous line) as necessary.
 - d. The patient is assessed periodically for level of consciousness, pain complaints, and complications, should they occur.

e. The patient's vital signs and clinically relevant findings are documented in the patient's medical record.

21. After the following criteria are met, the patient may be discharged from the PACU or ICU:

- a. The patient's vital signs are stable;
 - b. The patient's oxygen saturation levels are stable;
 - c. The patient's mental status has returned to the same mental status that the patient had prior to the procedure;
 - d. The patient's pain is being adequately controlled;
 - e. Any bleeding, nausea, or vomiting experienced by the patient is minimal;
- and,
- f. There is resolution of the neuraxial blockade (the numbing caused by the spinal or epidural must wear off so that there is a return of function to the affected area of the patient's body).

22. If a patient is scheduled to leave the medical facility the day of the procedure, the patient may be discharged from the medical facility when the following additional criteria are met:

- a. The patient can be discharged in the company of a competent adult; and,
- b. The patient has received understandable instructions that explain the following:
 - i. Telephone numbers that the patient can use to contact a physician to discuss complications or questions about post-operative care;
 - ii. Instructions for medications prescribed and pain management;
 - iii. Information regarding the patient's follow-up visit; and,
 - iv. Information regarding the designated treatment hospital in case of emergency.

23. In some instances, particularly in rural areas, anesthesia is administered by a CRNA under the supervision of a non-anesthesiologist physician such as a surgeon. In such instances, while the non-anesthesiologist physician's role and responsibilities are comparable to the above described roles and responsibilities of anesthesiologists, the specific tasks reserved to the supervising physician and those assigned to the CRNA will vary by institution, by the normal practice of each supervising physician in that institution, and by the particular circumstances in each instance of anesthesia care.

a. In some instances where the CRNA does not have prescriptive authority, particularly in a rural area, a physician, APNP or other authorized prescriber may prescribe the anesthetic medications which are administered by the CRNA.

EXAMPLES OF EMERGENCY ANESTHESIA COMPLICATIONS

24. The following paragraphs set out how some representative emergency anesthesia complications would generally be managed by an anesthesiologist and a CRNA, AA or anesthesiology resident working under the direction of the anesthesiologist.

a. CRNAs who have successfully completed an accredited nurse anesthesia program have the education and training necessary to successfully and independently administer anesthesia and respond to the emergencies described in the following paragraphs.

25. For example, a 56-year old man undergoes an uneventful laparoscopic cholecystectomy (surgical removal of the gallbladder through a tiny incision at the navel). The patient's past medical history is significant for smoking, hypertension, sleep apnea (a condition in which patients have abnormal ventilatory patterns), and obesity. Ten minutes after arrival to the post-anesthesia care unit, the post-anesthesia care nurse/the intensive care unit nurse notices that the patient is tachycardic (the patient's pulse is too high at 110 beats per minute). The patient's oxygen saturation is 88% on 100% inspired oxygen by facemask (oxygen saturation is supposed to be approximately 93-100% on room air). The nurse then checks to make sure the monitor is on and the oxygen is on the patient. If the nurse finds that both the monitor and the oxygen are working correctly, the nurse will call an anesthesiologist or a non-anesthesiologist physician. The anesthesiologist and the physician will immediately come to the patient's bedside. Because of the high pulse rate and the low oxygen saturation, the patient is considered to have post-operative hypoxemia (low oxygen levels). The following sets out the differential diagnosis and treatment for post-operative hypoxemia. The likelihood of a successful outcome depends greatly on making a prompt and correct diagnosis.

a. The post-operative hypoxemia could be caused by airway obstruction, which most commonly occurs in the pharynx or the area behind the tongue. This diagnosis is made from the patient's known history of sleep apnea and physical exam, revealing obstructive breathing and a dulled mental status. In this situation, the anesthesiologist or other physician also needs to determine if the patient's condition is due to narcotics or residual muscle relaxation, both of which can worsen airway obstruction. Initial treatment of this problem involves tilting the head of the patient backwards and/or

manually moving the jaw forward until the obstruction is relieved. If the patient's condition is due to narcotics, the patient may need medication (Naloxone) to reverse the narcotics' effect. If the patient's condition is due to residual muscle relaxation, the patient will need additional medications to increase strength and muscle tone. In severe cases of airway obstruction, the patient will require assisted ventilation with a mask and/or reintubation. The patient will also need further observation to make sure that the problem does not recur.

b. The patient's post-operative hypoxemia could be caused by inadequate pain relief. If the patient complains of inadequate pain relief, treatment consists of the administration of more analgesic medication.

c. The patient's post-operative hypoxemia could be caused by atalectasis of the lungs (temporary collapse of lung segments, decreasing the lungs' ability to oxygenate the blood). This complication is common after this procedure, particularly in an obese person. This complication can also be caused by secretions and/or blood, which can plug airway segments and cause their collapse. Atelectasis of the lungs would be diagnosed by physical exam (decreased breath sounds at the lung bases) and chest x-ray (decreased lung volumes at the base of the lungs). To treat atelectasis, the patient is given humidified oxygen, repositioned into a sitting position, and encouraged to breathe deeply. If the patient does not improve, there are other, more serious problems that have to be considered as described below.

d. The patient's post-operative hypoxemia could be caused by a pneumothorax (air trapped in the chest cavity). Pneumothorax is a known complication of laparoscopy. Pneumothorax is diagnosed by physical exam (breath sounds are decreased on the affected side) and chest x-ray (air is identified in the space around the lung tissue). The treatment for pneumothorax depends on the size of the pneumothorax and the patient's condition. A small pneumothorax (less than 20% of the lung cavity) that is not compromising the patient's condition may be treated with oxygen and observation until it resolves on its own. A larger pneumothorax (greater than 20% of the lung cavity) usually requires insertion of a tube into the patient's chest; this tube over time drains the air and allows the lung to heal and re-expand. Most patients with a pneumothorax should be observed in an intensive care unit (ICU) until the pneumothorax resolves or shrinks significantly. If not diagnosed promptly, pneumothorax can progress to a life-threatening condition, tension pneumothorax, in which the trapped air acutely decreases blood flow to the lungs and the heart's ability to pump blood. The diagnosis of tension pneumothorax must be made quickly; treatment consists of rapid placement of a chest tube (as described above) or a large intravenous cannula into the anterior chest in order to relieve the pressure on the lungs and heart.

e. The patient's post-operative hypoxemia could be caused by coronary ischemia (not enough oxygen getting to the heart), leading to reduced blood flow from the heart and pulmonary edema (fluid on the lungs). Coronary ischemia is diagnosed by the patient's history (assuming the patient reports chest pain or other symptoms suggesting ischemia), a physical exam (rales, crackling sounds in the lung bases that suggest heart failure) and 12-lead electrocardiogram (ECG). The ECG done at this time needs to be compared to the ECG done on the patient before surgery. In this comparison, the physician looks for any changes suggestive of ischemia and impending damage to the heart. The initial treatments for coronary ischemia aim to increase oxygen supply to, and reduce oxygen demand from, the heart. Therefore, the patient typically receives supplemental oxygen and medications such as beta-blockers, which reduce oxygen demand, and nitrates, which reduce oxygen demand and improve oxygen supply. Depending on the patient's condition, invasive monitoring (arterial line, central line) might be needed. In addition, a cardiologist must be consulted as soon as possible. If the patient's condition improves, the patient is likely transferred to the ICU for observation. If the patient's condition does not improve, the patient may need emergency cardiac catheterization to diagnose and treat coronary blockages before a heart attack occurs.

f. The patient's post-operative hypoxemia could be caused by an asthmatic attack. An asthmatic attack would be diagnosed primarily by physical exam revealing tachypnea (fast breathing) and wheezing. The treatment for an asthmatic attack includes the administration of humidified oxygen, medications to improve airflow in the lungs (nebulized bronchodilators), and steroids for stabilization. If the patient's condition is severe, the patient may need epinephrine (adrenalin, which causes immediate relaxation of the airways), invasive monitoring (arterial line) with frequent blood sampling to measure pH, oxygen, and carbon dioxide), or possibly reintubation.

g. The patient's post-operative hypoxemia could be caused by aspiration pneumonia (stomach contents passing into the lungs). Aspiration pneumonia would be diagnosed by looking at the patient's history (an event in the operative period suggesting aspiration), physical exam (decreased breath sounds, rales or both), and chest x-ray (though this might not be clear in the immediate stages). Aspiration pneumonia, though rare, has high mortality if not treated aggressively and promptly. The treatment for aspiration pneumonia would include the administration of oxygen and steroids. The patient may also need intubation, bronchoscopy and lavage (flushing the lungs with saline solution), and observation in the ICU.

h. The patient's post-operative hypoxemia could be caused by a pulmonary embolism (blockage in the pulmonary blood vessels caused by a blood clot or air bubble). Pulmonary embolism is suspected in a patient when the patient experiences sudden rapid breathing, chest pain, shortness of breath, or pulmonary effusion (fluid on the lungs). The symptoms of pulmonary embolism are vague and overlap with those of asthma or heart failure. If a pulmonary embolism is suspected, the treatment can range from oxygen to reintubation and pharmacologic support of blood pressure.

26. For example, a patient undergoing plastic surgery is receiving local anesthesia via an injection into the chest and

develops symptoms such as shortness of breath, hypotension (a drop in blood pressure), or tachycardia (an unusually fast heartbeat). These symptoms might evidence one of a number of different causes, ranging from inadequate amounts of anesthesia, an allergic reaction to the anesthesia, a pulmonary embolus (a blood clot in the lung or injected air into a major blood vessel), surgical bleeding (bleeding resulting from the surgery itself or bleeding caused by an injection of anesthesia that interrupts a major artery), a hemothorax (i.e. a needle puncture of a major artery), or a pneumothorax (i.e. a punctured lung caused by a needle). Each potential cause indicates a different form of treatment. For example, the treatment for light anesthesia would be to deepen the anesthesia. The treatment for an allergic reaction to the anesthesia could include treating the patient with vasopressors, giving the patient fluids, or giving the patient adrenaline. If the patient stops breathing due to the allergic reaction, the patient must be resuscitated. The treatment for a pulmonary embolus would include supporting the patient's blood pressure and the placement of invasive lines. The treatment for a pulmonary embolus could also include the administration of drugs such as dopamine if a patient becomes hypotensive due to the pulmonary embolus. The treatment for surgical bleeding is to find the site of the bleeding and to stop the bleeding. The treatment for either a pneumothorax or a hemothorax would include insertion of a chest tube to either fill the lung or to drain the lung.

27. Patients whose hearts have been damaged from previous heart attacks may undergo surgical procedures involving blood loss, during which their blood pressure drops suddenly. When that happens, it must be determined what caused the drop in pressure. If the drop in pressure was caused by the drugs required to anesthetize the patient (some drugs are potent vasodilators or cardiac suppressants), the treatment may require administration of drugs which will raise blood pressure (vasoconstrictors to increase heart contractility or rate). If the drop in pressure was caused by the loss of blood, the proper response would be to rapidly administer fluid and blood. Treatment may also require the administration of drugs designed to raise the blood pressure. However, if the patient is actually suffering an attack of myocardial ischemia (inadequate oxygen to the heart), the proper response might not include the rapid administration of blood or the administration of drugs designed to raise the blood pressure. The proper response to an attack of myocardial ischemia would include optimizing the level of oxygen, decreasing stress on the heart, supporting blood pressure, and providing the patient with aspirin. If the course of emergency response is erroneously chosen (i.e. the patient is given blood or fluid when instead the patient should have received blood pressure or heart support), the heart may not be able to handle the influx of a large volume of fluid and may go into cardiac arrest.

CONCLUSIONS OF LAW

- I. The Medical Examining Board has jurisdiction to decide this matter and has authority under Wis. Stat. § 227.41 to issue a declaratory ruling or to decline to issue a declaratory ruling.
- II. Petitioner WSA has not shown that it is entitled to a judgment on its Motion for Summary Judgment as a matter of law.
- III. The administration of anesthesia is part of the practice of medicine and surgery within the meaning of Wis. Stat. §§ 448.01 and 448.03(1).
- IV. The administration of anesthesia is the practice of the practice of professional nursing within the meaning of Wis. Stat. §441.001(4)(intro).
- V. A Certified Registered Nurse Anesthetist (CRNA) who is certified as an Advanced Practice Nurse Prescriber (APNP) and who administers anesthesia is lawfully practicing within the scope of a certificate granted to practice professional nursing under Wis. Stat. ch. 441.
- VI. A Certified Registered Nurse Anesthetist (CRNA) who is certified as an Advanced Practice Nurse Prescriber (APNP) and who administers anesthesia, is practicing within Wis. Stat. § 448.03(2)(a), an exception to the general requirement for physician licensing in Wis. Stat. § 448.03(1)(a), and is not required to have a license as a physician or be supervised by a physician.
- VII. A Certified Registered Nurse Anesthetist (CRNA) who is certified as Advanced Practice Nurse Prescriber (APNP) is required by Wis. Adm. Code § N 8.10(7) to work in a collaborative relationship with a physician.
- VIII. A Certified Registered Nurse Anesthetist (CRNA) who is not certified as Advanced Practice Nurse Prescriber (APNP) and who administers anesthesia, is practicing within Wis. Stat. § 448.03(2)(e), an exception to the general requirement for physician licensing in Wis. Stat. § 448.03(1)(a), and is not required to have a license as a physician, but is required to provide patient services, including administration of anesthesia, as directed, supervised and inspected by a physician.

Based on the record in this matter, the undersigned administrative law judge recommends that the State of

Wisconsin Medical Examining Board issue the following:

ORDER

NOW, THEREFORE, IT IS ORDERED That the Motion for Summary Judgment of the Petitioner Wisconsin Society Anesthesiologists shall be, and hereby is, DENIED;

IT IS FURTHER ORDERED That the Petition for Declaratory Ruling of the Wisconsin Society of Anesthesiologists shall be, and hereby is, DISMISSED.

/s/ William Dusso

William Dusso
Administrative Law Judge
Wisconsin Department of Regulation and Licensing
Dated: January 22, 2007

x

[1] Administrative rules of the BON define "advanced practice nurse" to include a registered nurse who has a current license to practice professional nursing and is currently certified by an approved national certifying body as a "certified registered nurse anesthetist." "Nurse anesthetist" is defined in Wis. Stat. § 655.001(9) as "... a nurse licensed under ch. 441 ... who is certified as a nurse anesthetist by the American Association of Nurse Anesthetists. Under Wis. Adm. Code § HFS 118.03 (27) "Nurse anesthetist" means a professional nurse licensed under ch. 441, Stats., who has obtained, through additional education and successful completion of a national examination, a certification as an anesthesia nursing specialist." Other similar definitions are at Wis. Adm. Code § HFS 105.055(1), and 42 CFR 410.69(b).

[2] The rule was published on November 13, 2001 at 66 FR 56762. The regulations adapted and amended 42 CFR Parts 416, 482, and 485. The

full text of the *Federal Register* adopting these regulations is at Tab A to *Memorandum Of Petitioner In Support Of Motion For Summary Judgment* and Exhibit B of WANA's *Memorandum In Opposition To The Summary Judgment Motion Of The Wisconsin Society of Anesthesiologists*. As amended, the conditions of participation for hospital anesthesia services, for example, state as follows:

TITLE 42--PUBLIC HEALTH

CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES--(Continued)

PART 482--CONDITIONS OF PARTICIPATION FOR HOSPITALS . . .

Subpart D--Optional Hospital Services . . .

Sec. 482.52 Condition of participation: Anesthesia services.

If the hospital furnishes anesthesia services, they must be provided in a well-organized manner under the direction of a qualified doctor of medicine or osteopathy. The service is responsible for all anesthesia administered in the hospital.

(a) Standard: Organization and staffing. The organization of anesthesia services must be appropriate to the scope of the services offered. Anesthesia must be administered only by--

- (1) A qualified anesthesiologist;
- (2) A doctor of medicine or osteopathy (other than an anesthesiologist);
- (3) A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law;
- (4) A certified registered nurse anesthetist (CRNA), as defined in Sec. 410.69(b) of this chapter, who, unless exempted in accordance with paragraph (c) of this section, is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed; or

(5) An anesthesiologist's assistant, as defined in Sec. 410.69(b) of this chapter, who is under the supervision of an anesthesiologist who is immediately available if needed.

(b) Standard: Delivery of services. Anesthesia services must be consistent with needs and resources. Policies on anesthesia procedures must include the delineation of preanesthesia and post anesthesia responsibilities. The policies must ensure that the following are provided for each patient:

(1) A preanesthesia evaluation by an individual qualified to administer anesthesia under paragraph (a) of this section performed within 48 hours prior to surgery.

(2) An intraoperative anesthesia record.

(3) With respect to inpatients, a postanesthesia followup report by the individual who administers the anesthesia that is written within 48 hours after surgery.

(4) With respect to outpatients, a postanesthesia evaluation for proper anesthesia recovery performed in accordance with policies and procedures approved by the medical staff.

(c) Standard: State exemption. (1) A hospital may be exempted from the requirement for physician supervision of CRNAs as described in paragraph (a)(4) of this section, if the State in which the hospital is located submits a letter to CMS signed by the Governor, following consultation with the State's Boards of Medicine and Nursing, requesting exemption from physician supervision of CRNAs. The letter from the Governor must attest that he or she has consulted with State Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the State and has concluded that it is in the best interests of the State's citizens to opt-out of the current physician supervision requirement, and that the opt-out is consistent with State law.

(2) The request for exemption and recognition of State laws, and the withdrawal of the request may be submitted at any time, and are effective upon submission.

[3] The opt-out provisions are in 42 CFR §§ 416.42(d), 482.52(c), and 485.639(e). A copy of Gov Doyle's letter is Exhibit 1 to Petitioner's *WSA Exhibits Binder* submitted with Petitioner's *Memorandum Of Petitioner In Support Of Motion For Summary Judgment* and Exhibit C of WANA's *Memorandum In Opposition To The Summary Judgment Motion Of The Wisconsin Society of Anesthesiologists*.

[4] Acronyms used in this decision are:

AA - Anesthesiology Assistants.

AANA - American Association of Nurse Anesthetists.

APN - Advanced practice nurse.

APNP - Advanced Practice Nurse Prescriber.

BON - State of Wisconsin Board of Nursing.

CMS - U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services.

CRNA - Certified Registered Nurse Anesthetist.

CRNA/APNP - A Certified Registered Nurse Anesthetist who is certified by the Board of Nursing as an Advanced Practice Nurse Prescriber.

DHFS - State of Wisconsin Department of Health and Family Services.

DRL - State of Wisconsin Department of Regulation and Licensing.

MAC - Monitored anesthesia care.

MEB - State of Wisconsin Medical Examining Board.

PACB - State of Wisconsin Podiatry Affiliated Credentialing Board.

PACU - Post-anesthesia care unit.

RN - Registered nurse.

WSA - Wisconsin Society of Anesthesiologists.

WANA - Wisconsin Association of Nurse Anesthetists.

WSPM - Wisconsin Society of Podiatric Medicine.

[5] See *Wis. Stat. § 806.04*; *22A Am Jur 2d Declaratory Judgments § 1*; *State ex rel. Chiarkas v. Skow*, 160 Wis. 2d 123, 131-132, 465 N.W.2d 625, 628 (1991).

[6] *Wisconsin Fertilizer Ass'n v. Karns*, 39 Wis. 2d 95, 107, 158 N.W. 2d 294, 300 (1968).

[7] *Memorandum of Petitioner in Support of Motion for Summary Judgment*, at 2-5.

- [8] *U.S. Oil Co. v. Midwest Auto Care Services, Inc.*, 150 Wis.2d 80, 86, 440 N.W.2d 825, 827 (Ct. App. 1989).
- [9] 73 Am Jur 2d Summary Judgment § 1
- [10] *Balele v. Wis. Pers. Comm'n*, 223 Wis. 2d 739, 745-46, 589 N.W. 2d 418, 421-22 (Ct. App. 1998).
- [11] Wis. Stat. § 802.08(2); *Green Spring Farms v. Kersten*, 136 Wis. 2d 304, 315, 401 N.W.2d 816, 820 (1987).
- [12] See *Strigenz v. Department of Regulation*, 103 Wis. 2d 281, 286, 307 N.W. 2d 664, 667 (1981); *Laufenberg v. Cosmetology Examining Board*, 87 Wis. 2d 175, 184, 274 N.W.2d 618 (1979).
- [13] *Gilbert v. State Medical Examining Bd.*, 119 Wis. 2d 168, 188, 349 N.W. 2d 68, 76 (1984); *State ex rel. Wis. Registration Bd. of Architects & Professional Engineers v. T. V. Engineers*, 30 Wis.2d 434, 438-39, 141 N.W. 2d 235, 237 (1966).
- [14] Wis. Stat. § 15.01(7) and 15.405 (7) and (7g).
- [15] Wis. Stat. § 15.01(5)(b).
- [16] Wis. Stat. § 227.10(1).
- [17] Wis. Stat. § 440.035(1).
- [18] Wis. Stat. § 440.045.
- [19] "Affiliated credentialing board" is defined in Wis. Stat. § 15.01(1g).
- [20] Wis. Stat. § 15.085(3)(b).
- [21] *Flejter v. Estate of Flejter*, 2000 WI App 26, ¶10, 240 Wis. 2d 401, 409, 623 N.W. 2d 552, 557; *Georgina G. v. Terry M. (In the Interest of Angel Lace M.)*, 184 Wis. 2d 492, 512, 516 N.W.2d 678, 684 (1994).
- [22] Wis. Stat. § 802.08. The procedure utilized for submitting and responding to proposed findings of fact is set forth in the *Second Amended Scheduling Order For Summary Judgment Motion* of July 25, 2006.
- [23] Under Wis. Stat. § 448.01(9) the "practice of medicine and surgery" means:
- (a) To examine into the fact, condition or cause of human health or disease, or to treat, operate, prescribe or advise for the same, by any means or instrumentality.
 - (b) To apply principles or techniques of medical sciences in the diagnosis or prevention of any of the conditions described in par. (a) and in sub. (2).
 - (c) To penetrate, pierce or sever the tissues of a human being.
 - (d) To offer, undertake, attempt or do or hold oneself out in any manner as able to do any of the acts described in this subsection.
- [24] 2001 OAG #1-01; 68 Wis. Op. Att'y Gen. at 319-30 (1979). Overlap between the medical and nursing professions is also discussed in an opinion of the Texas Attorney General, 1999 Tex. AG LEXIS 136.
- [25] 2001 OAG #1-01 10, 11.
- [26] See: Wisconsin Department of Regulation and Licensing. Certification for Advanced Practice Nurses. January 17, 2006. <http://drl.wi.gov/dept/forms/capn.pdf>. (Copied as Appendix A).
- [27] See Exhibit A, Affidavit of Francis Ross Gerbasi of WANA's *Memorandum In Opposition To The Summary Judgment Motion Of The Wisconsin Society of Anesthesiologists*.
- [28] Wis. Stat. § 441.16; Wis. Adm. Code § 8.04. See also: Wisconsin Department of Regulation and Licensing, Advanced Practice Nurse Prescriber – Credentialing, January 18, 2007, <http://drl.wi.gov/prof/nura/cred.htm>; License Lookup Health Professions, January 18, 2006. http://drl.wi.gov/drl/drlookup/LicenseLookupServlet?page=lookup_health.
- [29] Exhibits 10 - 39 to Petitioner's *WSA Exhibits Binder* submitted with Petitioner's *Memorandum Of Petitioner In Support Of Motion For Summary Judgment*.
- [30] The rule specifying collaboration requirements of APNPs, Wis. Adm. Code § N 8.10 (7), was published in the Wisconsin Administrative Register, October, 2000, No. 538, eff. 11-1-00.
- [31] *Wisconsin Administrative Register*, February, 1995, No. 470, eff. 3-1-95.
- [32] See Appendix B. *Wisconsin Administrative Register*, September 1999, No. 525, 18. Moen and Nania letters are copied from the Department of Regulation and Licensing Rulemaking file for CR99-126.
- [33] The legislative history of Clearinghouse Rule 99-126 is available at the Wisconsin Legislature Internet site <http://nxt.legis.state.wi.us/nxt/gateway.dll?f=templates&fn=default.htm> under "BILL HISTORIES" for the 1999 legislative session.
- [34] *Elections Bd. v. Wisconsin Mfrs. & Commerce*, 227 Wis. 2d 650, 597 N.W.2d 721 (1999); *Schoolway Transp. Co. v. DMV*, 72 Wis. 2d 223, 236-37, 240 N.W.2d 403 (1976); *Frankenthal v. Wisconsin Real Estate Broker's Board*, 3 Wis. 2d 249, 88 N.W.2d 352, reh'g den. 3 Wis. 2d 257A, 89 N.W.2d 825 (1958).
- [35] *Mallo v. Wis. Dep't of Revenue*, 2002 WI 70 ¶30, 253 Wis. 2d 391, 417, 645 N.W.2d 853, 865.
- [36] Wis. Adm. Code § 8.02(1)(b).
- [37] Wis. Adm. Code § N 8.06(1).
- [38] See Exhibits BON-2 (Affidavit of Linda M. Sanner, ¶1.), BON-3, and the "Clinical responsibilities checklist in BON-4.
- [39] *Memorandum Of Petitioner In Support Of Motion For Summary Judgment*, 31-32.
- [40] The BON contends that splitting the authority to prescribe from the authority to administer is impractical and would strain healthcare practice. *Board Of Nursing's Opposition To Petitioner's Motion For Summary Judgment*, 12-13.
- [41] Page G24, Wisconsin Legislative Reference Bureau, Drafting Record for 1993 Wisconsin Act 138, copied under Tab F of the *Memorandum of Petitioner in Support of Motion for Summary Judgment*.
- [42] *Memorandum of Petitioner in Support of Motion for Summary Judgment*, 30-32.
- [43] Page F11, Wisconsin Legislative Reference Bureau, Drafting Record for 1993 Wisconsin Act 138. See Appendix C.
- [44] "Statutory interpretation begins with the language of the statute. If the meaning of the statute is plain, we ordinarily stop the inquiry. *Kalal v. Circuit Court for Dane County*, 2004 WI 58, P45, 271 Wis. 2d 633, 681 N.W.2d 110. We assign the words in the statute their common, ordinary, and accepted meaning. *Id.* We also consider the context and structure of the statute. *Id.*, P46. We interpret statutes to avoid absurd or unreasonable results and to give effect to every word in the text." *Olstad v. Microsoft Corp.*, 2005 WI 121, ¶18, 284 Wis. 2d 224, 234, 700 N.W.2d 139, 144.
- [45] A CRNA/APNP is subject to the standards of professional conduct for registered nurses which, if violated, warrant disciplinary action,

including revocation and suspension. These standards prohibit acts which show the registered nurse, to be unfit or incompetent by reason of negligence. Wis. Stat. § 441.07(1)(c). For purposes of discipline the BON has defined "negligence" to mean: "Offering or performing services as a . . . registered nurse for which the licensee is not qualified by education, training or experience." Wis. Adm. Code § N 7.03(1)(intro) and (g). The Board's rules regulating APNPs provide in Wis. Adm. Code § N 8.05(3) that the APNP may "issue only those prescription orders appropriate to the advanced practice nurse prescribers areas of competence, as established by his or her education, training or experience."

[46] *State v. James P. (In re Chezron M.)*, 2005 WI 80, P24-28, 281 Wis. 2d 68 *Wisconsin Citizens Concerned for Cranes and Doves*, 2004 WI 40, 270 Wis. 2d 318, ¶17, 677 N.W.2d 612.

[47] See Stephen R. Miller, Legislative Reference Bureau, Wisconsin Bill Drafting Manual 2.01(1)(i) (2005-06).

[48] Section 80, 2001 Wisconsin Act 107, states:

Section 80. 441.11 (4) of the statutes is renumbered 441.001 (4) (intro.) and amended to read:

441.001 (4) ~~Practice of professional~~ Professional NURSING. (intro.) ~~The practice of professional nursing within the terms of this subchapter~~ "Professional nursing" means the performance for compensation of any act in the observation or care of the ill, injured, or infirm, or for the maintenance of health or prevention of illness of others, ~~which act that~~ requires substantial nursing skill, knowledge, or training, or application of nursing principles based on biological, physical, and social sciences, ~~such as the~~. Professional nursing includes any of the following:

(a) ~~The~~ The observation and recording of symptoms and reactions, ~~the~~.

(b) ~~The~~ The execution of procedures and techniques in the treatment of the sick under the general or special supervision or direction of a physician, podiatrist licensed under ch. 448, dentist licensed under ch. 447 or optometrist licensed under ch. 449, or under an order of a person who is licensed to practice medicine, podiatry, dentistry or optometry in another state if ~~that~~ the person making the order prepared the order after examining the patient in that other state and directs that the order be carried out in this state, ~~and the~~.

(c) The execution of general nursing procedures and techniques.

(d) ~~Except as provided in s. 50.04 (2) (b), the practice of professional nursing includes~~ the supervision of a patient and the supervision and direction of licensed practical nurses and less skilled assistants.

The note following section 80 of 2001 Wisconsin Act 107 states:

NOTE: Moves definition section to the beginning of the subchapter, modifies language, and modifies language for improved readability and conformity with current style. The defined terms are changed to reflect the actual terms used in ch. 441. 1981 Wis. Act 317 added the phrase, "Except as provided in s. 50.04 (2) (b), the practice of professional nursing includes", in sub. (4) to exclude activity under that provision from the definition of professional nursing. The amendment of sub. (4) applies the phrase "professional nursing includes" to all of the examples under the subsection for consistency and to avoid possible confusion.

[49] 67 Cal. Op. Att'y Gen. 122, 1984 Cal. AG LEXIS 68.

[50] See responses and replies of the parties to *Petitioner's Proposed Summary Judgment Findings of Fact* ¶12.

[51] The definition of "professional nursing" in section 2725 of the California Nursing Practice Act quoted in the opinion states:

"The practice of nursing within the meaning of this chapter means those functions including basic health care, which help people cope with difficulties in daily living which are associated with their actual or potential health or illness problem or the treatment thereof which require a substantial amount of scientific knowledge or technical skill, and includes all the following:

"(a) Direct and indirect patient care services that insure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures.

"(b) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.

"(c) The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries.

"(d) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (1) determination of whether such signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics; and (2) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures."

[52] 1984 Cal. AG LEXIS 68 at 3.

[53] *Memorandum of Petitioner in Support of Motion for Summary Judgment*, 28.

[54] Wis. Stat. § 441.16(3)(a).

[55] The legislature's findings in Section 1 of Act 37 were summarized in *State ex rel. Strykowski, v. Wilkie*, 81 Wis. 2d 491, 508; 533; 261 N.W.2d 434, 442 (1978).

. . . The legislature cited a sudden increase in the number of malpractice suits, in the size of awards, and in malpractice insurance premiums, and identified several impending dangers: increased health care costs, the prescription of elaborate "defensive" medical procedures, the unavailability of certain hazardous services and the possibility that physicians would curtail their practices. In addition, resolution of a malpractice claim under the traditional tort litigation process has been found to require an average of nineteen months. . . .

[56] The provisions of Wis. Stat. ch. 655 (1975) were unsuccessfully challenged as unconstitutional in *State ex rel. Strykowski v. Wilkie*, 81 Wis. 2d 491, 261 N.W.2d 434 (1978). Although classification issues were raised as an equal protection challenge, the classification of physicians, hospitals and nurse anesthetists as health care providers is not discussed in the opinion. The court concluded generally: "We believe there is a rational basis upon which the legislature could and did act when enacting Chapter 655." *Strykowski*, at 508.

[57] 1993 Wisconsin Act 473.

[58] Current Wis. Stat. § 655.005 was created as Wis. Stat. § 655.004 (1985) by s. 26, 1985 Wisconsin Act 340.

[59] Wis. Stat. §§ 50.32 to 50.39.

[60] Wis. Adm. Code § HFS 124.20(2)(a)4.

[61] Wis. Adm. Code § HFS 124.20(3)(b)3. – 5.

[62] Wis. Stat. § 15.085(3)(b): "The chairperson of an affiliated credentialing board shall meet at least once every 6 months with the examining board to which the affiliated credentialing board is attached to consider all matters of joint interest."

[63] CMS received over 28,500 comments on its proposed anesthesia requirements from hospitals, professional organizations, accrediting bodies, practitioners, and other individuals. 66 Federal Register 219 (13 Nov. 2001), 56703

[64] These findings were developed utilizing summary judgment procedures permitting a party to propose findings of fact and to contest proposed findings made by another party on the basis of admissible evidence. The procedure utilized for submitting and responding to proposed findings of fact is set forth in the *Second Amended Scheduling Order For Summary Judgment Motion* of July 25, 2006. These findings are based on agreement of the parties, the affidavits of Dr. Deborah Rusy and Dr. Brian G. McAlary and the conclusions reached in this decision regarding the responsibility of CRNAs. A proposed factual finding is included despite objections to the proposed finding if the proposed finding is material to the issues, consistent with the legal conclusions in this decision, and no supporting affidavits or other factual evidence is submitted to support the objection.

[65] The words "and prescription" as proposed by Petitioner were deleted from paragraph 3.a. based on the objection of the WANA and the discussion in the opinion regarding the respective authority of a CRNA/APNP and a CRNA not credentialed as an APNP.

[66] Paragraph 12.a. is based on the WANA's objection to Findings '12 – 23 and the affidavit of Dr. Brian G. McAlary, ¶ 5.

[67] Here, and generally, the assertion in the proposed findings submitted by the petitioner that the implementation of the anesthesia plan by a CRNA requires the CRNA to work under the direction of the anesthesiologist or that only an anesthesiologist may perform certain procedures is not included in these findings because the finding may be inconsistent with provisions of Wis. Stat. § 448.03(2)(a) and Wis. Adm. Code § N 8.10 (7) when the person administering the anesthesia is qualified as an APNP/CRNA.

[68] See Note 67.

[69] See Note 67.

[70] See note 67.

[71] See note 67.

[72] See note 65.

[73] See note 65.

[74] See note 65 and Wis. Adm. Code § 124.20(3)(b)5.

[75] See note 65.

PHYSICIAN'S DUTY:
INFORMATION AND ACCESS TO EMERGENCY
CONTRACEPTION

As a regulatory authority, the Wisconsin Medical Examining Board (MEB) is authorized to promulgate rules for the guidance of the members of the medical profession, including the definition and enforcement of standards for unprofessional conduct and unethical practices. At various times, questions or topics involving the professional responsibilities of physicians are presented to the MEB for consideration or clarification. A current topic of legislative interest is that of emergency contraception and the duty of health care providers, including physicians, to provide information and access to such care to victims of sexual assault. The policies of key medical organizations such as the American Medical Association (AMA) encourages physicians and other health care providers to play a more active role in providing education about emergency contraception and writing prescriptions for emergency contraceptives as requested by their patients. AMA Policy Statement: Emergency Contraception, 2005¹

The statutes and rules which govern the practice of medicine in Wisconsin impose a professional obligation on physicians to inform their patients of alternate viable modes of treatment. The statutory provision is found in Wis. Stat. § 448.30, Information on Alternate Modes of Treatment, which states, in pertinent part:

Any physician who treats a patient shall inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments.

The MEB has promulgated Wis. Admin. Code § Med 18.03(1) which specifically requires a physician to communicate alternate viable modes of treatment to a patient. This rule, which was adopted in 1983, states, in pertinent part:

¹The American College of Obstetricians and Gynecologists (ACOG) Legislative Issue Brief, Access to Emergency Contraception, 2007, supports and promotes measures and strategies to increase women's awareness and knowledge of emergency contraception and their ability to access emergency contraception without costly delays or the imposition of geographic, financial, attitudinal or legal barriers.

It is the obligation of a physician to communicate alternate viable modes of treatment to a patient. The communication shall include the nature of the recommended treatment, alternate viable treatments, and risks or complications of the proposed treatment sufficient to allow the patient to make a prudent decision.

The failure to inform a patient about the availability of all alternate viable medical modes of treatment is also included in the definition of unprofessional conduct in Wis. Admin. Code § Med 10.02(2)(u). Although the statute and rule allow for exceptions to the physician's duty to communicate alternate modes of treatment, these exceptions are exclusively patient-based and take into consideration the patient's condition and interest in obtaining appropriate health care treatment.² This is consistent with language in the administrative rule with respect to the duty to communicate to the patient:

In the communication with a patient, a physician shall take into consideration:

- (a) A patient's ability to understand the information;*
- (b) The emotional state of a patient; and*
- (c) The physical state of the patient.*

The physician's duty to communicate is particularly critical in situations where the provision of the information to the patient is time sensitive. In an emergency medical situation involving sexual assault if

² The administrative rule provides that nothing in the sub. (1) shall be construed as preventing or limiting a physician in recommending a mode of treatment which is in his or her judgment the best treatment for a patient. Wis. Admin. Code § Med 18.03(2). The physician's discretion with respect to the communication of alternate modes of treatment is further defined in Wis. Admin. Code § Med 18.04 which states that a physician is not required to explain each procedural or prescriptive alternative inherent to a particular mode of treatment. Nor is the physician held responsible for failure to inform a patient of possible complications or benefits not generally known to a reasonably well-qualified physicians in a similar medical classification. The rule also provides that the physician may not be held responsible for failure to communicate alternate modes of treatment to a patient if failure to provide immediate treatment would be more harmful to a patient than immediate treatment, would unduly confuse or frighten the patient, or if a patient refuses to receive the communication.

a physician fails to communicate an alternate mode of treatment, such as emergency contraception, in a timely manner the option or efficacy of the treatment could be compromised or irretrievably lost. Thus, the standard of care requires that a physician provide information on treatment alternatives in sufficient time so that the patient could make a prudent choice whether or not to accept the treatment. In addition, should the patient request emergency contraception, the physician must either provide such treatment or make a reasonable effort to facilitate patient access to such treatment without placing an undue burden on the patient and in a time frame which reflects the urgency of the situation.³ By failing to provide the sexual assault victim with timely information about emergency contraception, and when requested treatment or facilitation of such treatment a physician may be found to have departed from the standard of care ordinarily exercised by a minimally competent physician and engaged in a practice which constitutes a danger to the health safety and welfare of a patient in violation of Wis. Admin. Code §§ Med 10.02(2)(h), 10.02(2)(u) and 18.03, and may be subject to discipline for unprofessional conduct.

³ The Board does not endorse the physician's refusal to facilitate patient access to emergency contraception for personal reasons but does recognize the occasional need for referral due to logistical barriers.

Medical Examining Board Update-Important Changes in WI Law

June 2, 2010

On May 18th, Governor Doyle signed AB 877 into law as 2009 WI Act 382. This act, initiated by the Medical Examining Board (MEB) will be reviewed in detail in the Regulatory Digest to be published in July. This act makes a number of changes to Wisconsin law.

- * The act places a legal duty upon all licensed physicians (MD and DO) to report other physicians to the MEB under circumstances detailed in the law.
- * The prescribing limitation on residents working under a Temporary Educational Permit is eliminated.
- * Changes are made to the MEB process for issuing summary license suspensions.
- * The MEB is granted the ability to change Continuing Medical Education requirements by rule rather than by legislation.

The intent of the new law is to protect of patients and the public. This bill was initiated by the MEB in an effort to improve our ability to protect the public from physicians who may pose a threat to their patients. The duty to report codifies ethical obligations which exist in policy statements of the Wisconsin Medical Society and American Medical Association and creates a duty similar to what exists in the laws of many other states. It was created with the knowledge that physicians are in the best position to be aware of colleagues who may engage in a pattern of unprofessional conduct; engage in acts creating an immediate or continuing danger to patients or the public; may be medically incompetent; or may be mentally or physically unable to safely practice medicine. Failure to report such physicians may under the law lead to discipline by the MEB.

This law applies to all licensed physicians without exclusion and thus, we realize, may create a conflict for some physicians, particularly those engaged in medical management/peer review and those physicians treating other physicians for psychiatric and substance abuse problems. Complete guidance will be forthcoming on these issues.

Reports should be made to the Wisconsin Department of Regulation and Licensing (DRL), in writing and contain sufficient detail to allow appropriate investigation. Information on how to file a complaint is available on the DRL website at www.drl.wi.gov. The filing of a complaint does not automatically result in a disciplinary action. Actions by the MEB are judicial in nature and respondents (those reported) have full rights to due process before any adverse action may be taken against them. The full text of 2009 WI Act 382 can be found on-line at: <http://www.legis.state.wi.us/2009/data/acts/09Act382.pdf>

Sincerely,

Dr. Sujatha Kailas
Chair-Medical Examining Board

Dr. Gene Musser
Immediate Past Chair-Medical Examining Board

Medical Examining Board of the State of Wisconsin
Position Statement on Pain Management

The mission of The Medical Examining Board is to promote and protect the health and welfare of the citizens of the State of Wisconsin by fostering the provision of safe and competent medical care. The Board recognizes that such care involves the provision of appropriate and effective management of pain.

The under treatment of pain continues to be a significant public health problem in the United States. Inadequate pain control may result from physicians' lack of knowledge about pain assessment and management and/or their misunderstanding of the safety and efficacy of opioid analgesics, drugs that are essential for the management of moderate to severe pain. Physicians may also fear investigation or sanction by federal, state and local agencies which may lead to inappropriate treatment of pain.

The Board encourages physicians to view effective pain assessment and management as part of quality medical care for all patients with pain, whether it is acute or chronic. It is especially important for patients who are experiencing pain at the end of life. All physicians should be knowledgeable about effective methods of pain assessment and treatment as well as the statutory requirements for prescribing controlled substances. The medical management of pain should be guided by current knowledge and acceptable medical practice, which includes the use of both pharmacologic and non-pharmacologic modalities. Pain should be assessed and treated promptly and appropriately with clear documentation.

The Board recognizes that opioid analgesics are subject to abuse by individuals who seek them for mood altering and other psychological effects rather than for legitimate medical purposes. Physicians who use these drugs in the course of treatment should be diligent and incorporate established safeguards into their practices to minimize the potential for their diversion and abuse.

The Board further recognizes that tolerance and physical dependence are normal consequences of the sustained use of opioid analgesics and are not synonymous with psychological dependence (addiction). Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial and environmental factors influencing its development and manifestations. It is characterized by behaviors that include: impaired control over drug use, craving, compulsive use, and continued use despite harm. Persons with a history of drug abuse have the right to appropriate pain management, even if opioids must be used. Such persons may require specialized care. Tolerance may occur but it is not an inevitable consequence of chronic opioid therapy. Physical dependence is a normal and predictable state of adaptation to a drug, and by itself, does not equate with addiction.

Physicians should not fear disciplinary action from the Board for administering controlled substances, including opioid analgesics, for a legitimate medical purpose in the usual course of professional practice. The Board will initially consider the use of controlled substances for the treatment of pain to be for a legitimate medical purpose based on accepted scientific knowledge of the treatment of pain, patient clinical presentation and sound clinical

judgment. Proper written documentation, the patient's medical condition and clinical response to treatment provide strong foundations for verifying optimal patient care, if review of the patient record is necessitated at some future time.

The Medical Examining Board of the State of Wisconsin is adopting and disseminating this position statement to support and encourage safe, competent, and high quality medical care for persons with pain. By so doing, the Board clearly communicates to physicians that it:

- 1) encourages safe and effective pain management practices
- 2) recognizes that pain management, which may involve the use of opioid analgesics, is a critical part of medical practice
- 3) will not sanction physicians solely for providing opioid analgesics provided the physician administers the medication in a safe and effective manner in compliance with state and federal law.

Position statement developed in collaboration with the WI Pain Initiative, 1300 University Avenue, Madison, WI <http://aspi.wisc.edu/wpi/>

POSITION PAPER

EXPEDITED PARTNER THERAPY FOR SEXUALLY TRANSMITTED DISEASES

- The Wisconsin Medical Examining Board (MEB) recognizes that the adequate treatment of sexually transmitted diseases (STDs), such as gonorrhea and chlamydia infections, is an important public health issue.
- The MEB recognizes that physicians and other health-care providers play a critical role in preventing and treating STDs.
- The MEB recognizes that adequate treatment and prevention of these infectious diseases often depends on the treatment of the partner(s) of a patient who may not be available or agreeable to direct examination by the physician.
- The MEB further recognizes that it has been common practice for physicians to provide antibiotics for the partner(s) of a patient with an STD without prior clinical examination of the partner, and while this practice is not ideal in terms of diagnosis and prescriptive practice, it is often the only realistic way to reduce the incidence of reoccurrence and transmission of the diseases.
- The United States Centers for Disease Control and Prevention (CDC) has recommended an emerging alternative to traditional partner management for STDs which involves the delivery and prescription of medications to STD patients for their partners without the clinical assessment of the partners. The CDC issued treatment guidelines in 2006 for this form of practice which is known as the "Expedited Partner Therapy" (EPT).
- The American Medical Association has endorsed the practice of EPT as applied to chlamydia and gonorrhea infections. (June 2006)
- The Wisconsin Division of Health and Family Services has also adopted regulations for Sexually Transmitted Diseases Treatment which reference and incorporate the CDC treatment guidelines for EPT. HFS § 145.22, Wis. Admn. Code
- The practice of EPT in accordance with the CDC guidelines may constitute the standard of care with respect to the treatment of STDs of patients with absent partners to reduce the incidence of reoccurrence and transmission of the diseases.
- Given that the public risk of untreated STDs is greater than the risk of complications from dispensing in this less than ideal setting, the MEB recognizes the CDC guidelines for the practice of EPT and supports the passage of legislative authority to expressly authorize the provision of EPT treatment by licensed physicians in Wisconsin.

- Accordingly, until such legislative authority is secured, the MEB recommends that physicians use all reasonable measures available to ensure that appropriate treatment is made available to the patient's partners. These measures may include offers for low-cost or no-cost examination by the physician of the patient or the referrals to other providers in the community that may offer such services. If an examination of the patient's partner(s) is not feasible, the physician could choose to follow the CDC guidelines as well as other applicable prescription labeling. For example, the prescription label should include the patient's own name and the partner(s) name or, if unknown, the patient's name followed by the word "partner." The physician should also assign a separate and unique identifying number to each prescription and clearly identify this number on each corresponding prescription label. The physician should follow appropriate health care record-keeping and provide advice and direction to the patient's partner(s) for use of the medications, including adverse reactions, complications and the need for follow-up care. These recommendations may serve as a course of clinical guidance; however each physician or health care provider should always consider the individual clinical circumstances of each person in the context of local disease prevention.



EXECUTIVE ORDER # 50

Relating to Guidelines for the Promulgation of Administrative Rules

WHEREAS, 2011 Wisconsin Act 21 reformed the administrative rulemaking process in Wisconsin in order to increase accountability, clarify agency regulatory authority, and evaluate the economic impact of all new and amended state administrative rules; and

WHEREAS, Wis. Stat. § 227.10(1) requires that each agency statement of policy and each interpretation of a statute adopted to govern its enforcement or administration of that statute shall be promulgated as a rule, and Wis. Stat. § 227.01(13) defines a rule as “a regulation, standard, statement of policy or general order of general application which has the effect of law and which is issued by an agency to implement, interpret or make specific legislation enforced or administered by the agency or to govern the organization or procedure of the agency;” and

WHEREAS, Wis. Stat. § 227.10(2m) requires an explicit grant of authority under statute or administrative rule before a state agency can implement or enforce any standard, requirement, or threshold, including as a term or condition of any license issued by the agency; and

WHEREAS, Wis. Stat. §§ 227.11(2)(a)1. to 3. defines agency authority to promulgate administrative rules, specifically providing the following:

- A statutory or nonstatutory provision containing a statement or declaration of legislative intent, purpose, findings, or policy does not confer rulemaking authority on the agency or augment the agency’s rulemaking authority beyond the rulemaking authority that is explicitly conferred on the agency by the legislature.
- A statutory provision describing the agency’s general powers or duties does not confer rulemaking authority on the agency or augment the agency’s rulemaking authority beyond the rulemaking authority that is explicitly conferred on the agency by the legislature.
- A statutory provision containing a specific standard, requirement, or threshold does not confer on the agency the authority to promulgate, enforce, or administer a rule that contains a standard, requirement, or threshold that is more restrictive than the standard, requirement, or threshold contained in the statutory provision; and

WHEREAS, Wis. Stat. §§ 227.135(2), 227.24(1)(e)1d. requires the Governor to approve a statement of scope before an agency may proceed with rulemaking, Wis. Stat. § 227.185 requires the Governor to approve a final draft rule before it is submitted to the Legislature for review, and Wis. Stat. § 227.24(1)(e)1g. requires the Governor to approve an emergency rule before it is filed with the Legislative Reference Bureau and published in the official state newspaper; and

WHEREAS, Wis. Stat. § 227.137 requires state agencies to complete an Economic Impact Analysis (EIA) for every proposed rule in coordination with local governmental units that may be affected and to solicit information and advice from and consult with businesses,

associations representing businesses, local governmental units and individuals that may be affected by the proposed rule; and

WHEREAS, Wis. Stat. § 227.10(2m) establishes that “[t]he Governor, by executive order, may prescribe guidelines to ensure that rules are promulgated in compliance with [Subchapter II of Chapter 227 of the Wisconsin Statutes].”

NOW THEREFORE, I, Scott Walker, Governor of the State of Wisconsin, by virtue of the authority vested in me by the Constitution and the laws of Wisconsin, specifically Wis. Stat. § 227.10(2m), do hereby direct that state agencies shall comply with the requirements of Subchapter II of Chapter 227 and this Executive Order when promulgating administrative rules.

I. General Provisions

1. To assure timely and proficient review of administrative rules in accordance with this Executive Order and with Wis. Stat. § 227.10(2m), the Governor’s Office of Regulatory Compliance is hereby established.
2. Each agency that develops any document interpreting, clarifying, or explaining statutes and rules that regulate individuals or entities or local governmental units, shall submit a copy to the Governor’s Office of Regulatory Compliance via AdministrativeRules@Wisconsin.gov prior to its finalization by that agency.
3. Each agency shall submit to the Governor’s Office of Regulatory Compliance all materials required to be submitted under Subchapter II of Chapter 227. This includes all publicly available materials submitted to the Legislative Council Rules Clearinghouse, Legislative Reference Bureau, Department of Administration, Chief Clerks of the State Assembly and State Senate, legislative standing committees, and the Joint Committee for Review of Administrative Rules.
4. The electronic submission of materials to the State Budget Office, via SBOAdminRules@wisapps.wi.gov or as the State Budget Office otherwise prescribes, shall fulfill an agency’s duty, under Chapter 227 and Paragraph I.3. of this Executive Order, to submit materials to the Governor, the Governor’s Office of Regulatory Compliance, or the Department of Administration.
5. Each statement of scope submitted by an agency on or after June 8, 2011 is subject to review and approval by the Governor as required by Wis. Stat. §§ 227.135(2), 227.24(1)(e)1d. and Paragraph II.1. of this Executive Order. An EIA shall be prepared as required by Wis. Stat. § 227.137 and Paragraph IV.1. of this Executive Order if the draft rule is submitted to the Legislative Council Rules Clearinghouse under Wis. Stat. § 227.15 on or after June 8, 2011. An EIA is not required when an agency promulgates an emergency rule. A final draft rule or emergency rule is subject to review and approval by the Governor, as required by Wis. Stat. §§ 227.185, 227.24(1)(e)1g. and Paragraph V.1. of this Executive Order, if the statement of scope for the rule or emergency rule was submitted on or after June 8, 2011.
6. The language of Wis. Stat. § 990.001(11) concerning severability and Wis. Stat. § 990.01 concerning construction of words and phrases are intended to apply to this Executive Order.

II. Statements of Scope

1. A statement of scope shall be submitted to the Governor’s Office of Regulatory Compliance for approval by the head of the agency proposing a rule or emergency rule or by a deputy or executive assistant who has been authorized to do so by the agency head under Wis. Stat. §§ 15.04(2) or 15.05(3). Statements of scope shall be submitted electronically, as prescribed in Paragraph I.4. of this Executive Order, and contain the following information as required by Wis. Stat. § 227.135(1).
 - a. A detailed description of the objective of the rule.

- b. A detailed description of existing policies relevant to the rule and new policies proposed to be included in the rule and an analysis of policy alternatives. The description shall include an overview of the requirement or program that the rule will implement. If the proposed rule will amend an existing rule, the description shall also include an overview of the existing rule and the general changes. If the proposed rule will replace an emergency rule currently in effect, the agency shall summarize the status of any legislative action under Wis. Stat. § 227.24(2) or § 227.26(2) and identify any implementation issues that have arisen since the rule was promulgated.
 - c. A detailed description of the statutory authority for the rule. The agency shall reference each statute that authorizes the promulgation of the proposed rule and each statute or rule that will affect the proposed rule or be affected by it. The agency shall also explain in detail the agency's authority to promulgate the proposed rule under those statutes. An agency shall rely on an explicit grant of authority from the Legislature to promulgate a rule, if one exists. An agency shall not rely upon general statements of legislative purpose or legislative findings or agency general powers and duties clauses to confer authority to promulgate rules. Pursuant to Wis. Stat. § 227.11(2)(a), in the absence of an explicit grant of rulemaking authority, an agency may promulgate a rule if:
 - i. The agency considers it necessary to effectuate the purpose of the statute; and
 - ii. The agency has a general grant of rulemaking authority to administer or enforce the chapter, subchapter, or section of the Wisconsin statutes.
 - d. An estimate of the amount of time that state employees will spend to develop the rules and of other resources necessary to develop the rule.
 - e. A description of all of the entities that may be affected by the rule. This includes a description of any local governmental units, businesses, economic sectors, or public utility ratepayers who may reasonably be anticipated to be affected by the rule.
 - f. A summary and preliminary comparison, with state law, of any existing or proposed federal regulation that is intended to address the activities to be regulated by the rule.
2. A statement of scope shall also include a statement of whether the agency anticipates that the proposed rule will have minimal or no economic impact, may have a moderate economic impact, or is likely to have a significant economic impact locally or statewide.
 3. A statement of scope for a proposed emergency rule shall also include an explanation of why the rule is necessary for the preservation of the public peace, health, safety, or welfare. If the rule is exempt from the required finding of emergency, the statement of scope shall cite the Wisconsin Act number and section authorizing the promulgation of an emergency rule or the statute section providing the exemption. The statement of scope shall also indicate whether the agency will promulgate a non-emergency rule and when it will begin the non-emergency rulemaking process.
 4. An agency that intends to simultaneously draft an emergency and a non-emergency rule that are identical in substance may submit one scope statement indicating this intent.
 5. Pursuant to Wis. Stat. § 227.135(2), no state employee may begin work on a proposed rule or emergency rule until the statement of scope has been approved by the Governor, published in the Administrative Register, and approved by the agency head or body with policy making powers for the agency.
 6. A statement of scope not submitted in accordance with Wis. Stat. § 227.135(1) and this Executive Order will be returned to the agency and the Governor's Office of

Regulatory Compliance's review will be suspended until a complete description and analysis is resubmitted.

7. The Governor's Office of Regulatory Compliance may request an agency to withdraw a statement of scope and resubmit separate statements of scope if, in the Governor's discretion, the original statement of scope encompasses more than one rule change.
8. Following a review of the statement of scope, the Governor's Office of Regulatory Compliance shall notify the agency in writing whether the statement of scope is approved or disapproved. A disapproval by the Governor may be accompanied by suggested modifications in the event an agency chooses to submit a revised statement of scope.
9. An agency must file a statement of scope approved by the Governor for publication by the Legislative Reference Bureau within thirty calendar days of approval if the agency intends to proceed with rulemaking, or the Governor's Office of Regulatory Compliance will deem the statement of scope to be withdrawn.
10. If at any time during the rulemaking process prior to final approval by the Governor, the scope of a proposed rule is changed in any meaningful or measureable way, including changing the scope so as to include any activity, business, material or product that is not specifically included in the original statement of scope under Wis. Stat. § 227.135(4), a revised statement of scope shall be submitted to the Governor's Office of Regulatory Compliance for approval. A meaningful or measurable change includes a change to the following:
 - a. The objectives of the proposed rule;
 - b. The basis and purpose of the proposed rule;
 - c. The policies to be included in the proposed rule;
 - d. The entities affected by the proposed rule; or
 - e. The overall breadth or scope of the regulation in the proposed rule.
11. If at any time following the Governor's approval of a statement of scope, prior to the submission of a final draft rule to the Legislature for review, the Governor's Office of Regulatory Compliance requests a revised statement of scope from the agency because the rule has been changed in a meaningful or measureable way under Wis. Stat. § 227.135(4), the agency shall submit the revised statement of scope to the Governor's Office of Regulatory Compliance electronically as prescribed in Paragraph I.4. of this Executive Order within fourteen calendar days of receiving the request.

III. Additional Agency Actions in the Rule-Making Process

1. If an agency intends to establish an advisory committee under Wis. Stat. § 227.13, it shall provide a list of members to the Governor's Office of Regulatory Compliance via AdministrativeRules@Wisconsin.gov prior to establishing the advisory committee.
2. The agency's draft rule analysis required under Wis. Stat. § 227.14(2) shall be submitted to the Governor's Office of Regulatory Compliance electronically, as prescribed in Paragraph I.4. of this Executive Order, upon completion and prior to finalization and submittal to the Legislative Council under Wis. Stat. § 227.15(1). In accordance with Wis. Stat. § 227.14(2m), the agency shall include a statement within the analysis describing how the requirements for ensuring the accuracy, integrity, objectivity and consistency of data were used in preparing the proposed rule and related analysis.

IV. Economic Impact Analysis

1. For each proposed rule that is not an emergency rule, an Economic Impact Analysis (EIA) shall be submitted to the Legislative Council, the Governor, the Department of Administration, and the Legislature by the head of the agency proposing a rule as required by § 227.137(4). An EIA shall be submitted electronically to the

Governor's Office of Regulatory Compliance as prescribed in Paragraph I.4. of this Executive Order and this submission shall also fulfill the requirement under § 227.137(4) to submit the EIA to the Governor and the Department of Administration.

2. Prior to initiating an EIA of a proposed rule, the agency shall review the statement of scope to determine whether it was changed in any meaningful or measureable way, under Wis. Stat. § 227.135(4) and Paragraph II.10. of this Executive Order, while the rule was being developed. If a meaningful or measurable change has been made, the agency shall revise and resubmit the statement of scope for approval as required by Wis. Stat. § 227.135(4) and Paragraph II.10. of this Executive Order.
3. In preparing an EIA, under Wis. Stat. § 227.137(3), the agency shall solicit information and advice from businesses, business sectors, associations representing business, local governmental units, and individuals that may be affected by the proposed rule by making information about the rule available and requesting comments.
 - a. Information including the proposed rule language shall be made available by posting on the agency website and the Wisconsin administrative rules website, submitting the information to the Governor's Office of Regulatory Compliance, as prescribed in Paragraph I.4. of this Executive Order, and by e-mailing individuals who have requested to receive information and other persons identified by the agency as potentially interested parties.
 - b. The agency shall accept comments for a period of at least fourteen calendar days if the statement of scope indicates that the draft rule will have no or minimal economic impact locally or statewide, at least thirty calendar days if the statement of scope indicates a moderate economic impact locally or statewide and at least sixty calendar days if the statement of scope indicates that the draft rule may or is likely to have a significant economic impact locally or statewide or on a sector of the economy. If the agency determines that the anticipated economic impact will be greater than indicated in the statement of scope, it shall adjust the comment period accordingly and a revised statement of scope is not required. If an agency determines that the anticipated economic impact will be less than indicated in the statement of scope, it may adjust the comment period accordingly and a revised statement of scope is not required.
 - c. The agency shall review the comments received and the statement of scope description of all of the persons that may be affected by the proposed rule. The agency shall update the list of businesses, business sectors, associations representing businesses, local governmental units, and individuals included in the statement of scope and submit the list to the Governor's Office of Regulatory Compliance via AdministrativeRules@Wisconsin.gov.
4. After soliciting information and advice from businesses, business sectors, associations representing business, local governmental units, and individuals that may be affected by the proposed rule, the agency shall prepare the EIA in coordination with the local governmental units that respond to the agency's solicitation of comments and request to coordinate with the agency, as required by Wis. Stat. § 227.137(3). The agency shall contact those local governmental units to discuss such comments and incorporate them into the EIA to the extent feasible. The agency may at the same time consult with the local governmental units about whether the proposed rule would adversely affect in any material way the economy, a sector of the economy, productivity, jobs or the overall economic competitiveness of the state as required by Wis. Stat. § 227.137(3)(e) and Paragraph IV.3. of this Executive Order.
5. After soliciting information and advice from businesses, business sectors, associations representing business, local governmental units, and individuals that may be affected by the proposed rule, the agency shall make a determination in the EIA as required by Wis. Stat. § 227.137(3)(e), in consultation with those businesses, business sectors, associations representing businesses, local governmental units, and individuals as to whether the proposed rule would adversely affect in a material way

the economy, a sector of the economy, productivity, jobs, or the overall economic competitiveness of this state in the following manner:

- a. The agency shall compile a list of affected persons and economic concerns identified in the comments solicited by the agency.
 - b. The agency shall contact those affected persons to discuss economic concerns and give consideration to those concerns in its EIA determination.
 - c. The agency shall document in the EIA the affected persons who were consulted and whether the agency's determination is disputed by any of the affected persons.
6. For purposes of developing an EIA for a proposed rule that is anticipated to have a significant economic impact locally or statewide, or on a sector of the economy, agencies are encouraged to establish an advisory committee of affected persons following its solicitation of comments in order to coordinate with local governmental units and consult with other affected persons. An agency that previously established an advisory committee under Wis. Stat. § 227.13 to advise it during rulemaking, including the development of the EIA, shall add to the committee affected persons, identified following the agency's solicitation of comments, who wish to serve on the committee.
7. The final EIA shall contain the following information as required by Wis. Stat. § 227.137 on the economic impact of the proposed rule on specific businesses, business sectors, public utility ratepayers, local governmental units, and the state's economy as a whole:
- a. An analysis and quantification of the policy problem that the proposed rule is intending to address, including comparisons with approaches used by the federal government and by Illinois, Iowa, Michigan, and Minnesota to address the policy problem and, if the approach chosen by the agency to address that policy problem is different from those approaches, a statement as to why the agency chose a different approach.
 - b. An analysis and detailed quantification of the economic impact of the proposed rule, including the implementation and compliance costs that are reasonably expected to be incurred by the businesses, local government units, and individuals that may be affected by the proposed rule. A summary of comments related to the implementation and compliance costs received by businesses, local governmental units, and individuals shall be included in the final analysis.
 - c. An analysis of the actual and quantifiable benefits of the proposed rule, including an assessment of how effective the proposed rule will be in addressing the policy problem that the rule is intended to address.
 - d. An analysis of the alternatives to the proposed rule including the alternative of not promulgating the proposed rule.
 - e. A determination made in consultation with the businesses, local governmental units, and individuals that may be affected by the proposed rule as to whether the proposed rule would adversely affect in a material way the economy, a sector of the economy, productivity, jobs, or the overall economic competitiveness of this state. Included in the final analysis shall be a summary of comments related to whether the proposed rule would adversely affect, in a material way, the economic competitiveness of this state received by businesses, local governmental units, and individuals.
 - f. If the agency finds that a proposed rule will not have an economic effect on public utilities or their ratepayers, it shall state this conclusion in the EIA. If the agency finds that a proposed rule will have an economic impact on public utilities or their ratepayers or both, it shall request the information necessary from the Public Service Commission to provide an estimate of the increased costs or resulting savings for public utilities and their ratepayers.

- g. Pursuant to Wis. Stat. § 227.137(3)(f), if an EIA relates to a rule of the Department of Safety and Professional Services establishing standards for dwelling construction, the EIA shall address whether the rule would increase the cost of constructing or remodeling the dwelling by more than \$1,000.
8. If the agency finds that a proposed rule will not have an economic impact after a review of comments submitted in response to the agency's solicitation, it may complete the EIA without additional coordination with local governmental units or consultation with other affected parties. The agency shall detail in the EIA the information supporting the conclusion that the proposed rule will not have an economic impact.
9. If at any time after the final EIA is submitted under Wis. Stat. § 227.137(4) and before the final draft rule is submitted to the Governor's Office of Regulatory Compliance for an approval, the economic impact of the proposed rule is significantly changed, a revised EIA shall be submitted to the Legislative Council, the Legislature, the Department of Administration, and the Governor, as required by under Wis. Stat. § 227.137(4).
- a. A significant change includes an increase or a decrease of at least 10 percent or \$50,000, whichever is greater, in the estimated compliance costs reasonably expected to be incurred by a majority of the businesses, business sector, local governmental units, or individuals that may be affected by the proposed rule or a significant change in the persons affected by the proposed rule.
- b. If in addition to a significant change in the economic impact of the proposed rule, there is also a meaningful or measureable change in the scope of the rule, the agency shall prepare a revised statement of scope and submit it to the Governor's Office of Regulatory Compliance for approval as required by Wis. Stat. § 227.135(4) and Paragraph II.10. of this Executive Order. If a revised statement of scope is approved by the Governor, published in the Administrative Register and approved by the agency head or body with policy making powers for the agency, the agency shall prepare the revised EIA in accordance with Wis. Stat. § 227.137 and Paragraph IV.9. of this Executive Order.
- c. If a revised statement of scope is not required because the scope of the proposed rule has not changed in a meaningful or measurable way, the agency may proceed with the development of the revised EIA using the list of businesses, business sectors, local governmental units, and individuals affected by the proposed rule developed following the agency solicitation of information and advice under Wis. Stat. § 227.137(3) and Paragraph IV.3. of this Executive Order. The agency shall comply with the remaining requirements of Wis. Stat. § 227.137 and this Executive Order.
10. If at any time after the final EIA is submitted under Wis. Stat. § 227.137(4), the Governor's Office of Regulatory Compliance requests a revised EIA because the economic impact of the proposed rule has significantly changed under Wis. Stat. § 217.137(4) and Paragraph IV.9. of this Executive Order, the agency shall submit the revised EIA electronically as prescribed in Paragraph I.4. of this Executive Order within ninety calendar days of receiving the request.
11. If the final EIA submitted under Wis. Stat. § 227.137(4) indicates that a total of \$20,000,000 or more in implementation and compliance costs are reasonably expected to be incurred or passed along to businesses, local governmental units and individuals as a result of the proposed rule, the Department of Administration shall review the rule and issue a report under Wis. Stat. § 227.137(6). Any cost savings identified in the analysis of actual and quantifiable benefits as required by Wis. Stat. § 227.137(3)(c) shall not reduce the total estimated implementation and compliance costs for purposes of determining whether the Department of Administration shall issue a report under Wis. Stat. § 227.137(6).
12. If the Department of Administration is required to complete a report under Wis. Stat. § 227.137(6), an agency shall not submit a proposed rule to the legislature for review under § 227.19(2) until the report has been received.

13. If an agency makes modifications to a proposed rule following the agency public hearing, the agency shall review the rule to determine whether the scope has been changed in any meaningful or measurable way under Wis. Stat. § 227.135(4) and Paragraph II.10. of this Executive Order and whether the economic impact of the proposed rule is significantly changed under Wis. Stat. § 227.137(4) and Paragraph IV.9. of this Executive Order.
 - a. The agency shall notify the Governor's Office of Regulatory Compliance via AdministrativeRules@Wisconsin.gov if it will submit a revised statement of scope to the Governor's Office of Regulatory Compliance for approval or a revised EIA to the Governor's Office of Regulatory Compliance, the Department of Administration, the Legislative Council Rules Clearinghouse and the Legislature, or both a revised statement of scope and a revised EIA. A revised statement of scope shall be submitted to the Governor's Office of Regulatory Compliance electronically as prescribed in Paragraph I.4. of this Executive Order within seven calendar days of the notification.
 - b. If neither a revised statement of scope nor a revised EIA is required, the agency shall submit the final draft rule to the Governor's Office of Regulatory Compliance for approval within thirty calendar days of the close of the public comment period following the public hearing if it intends to proceed with rulemaking, unless the agency has a policy making board that is required to approve the final rule language before it is submitted to the Governor's Office of Regulatory Compliance.

V. Final Draft Rule

1. A final draft rule shall be submitted electronically as prescribed in Paragraph I.4. of this Executive Order to the Governor's Office of Regulatory Compliance for approval by the head of the agency proposing a permanent or emergency rule or by a deputy or executive assistant who has been authorized to do so by the agency head under Wis. Stat. §§15.04(2) or 15.05(3).
2. For each non-emergency rule, the final draft rule submitted to the Governor's Office of Regulatory Compliance shall contain the following information:
 - a. The documents required under Wis. Stat. § 227.15(1), with any necessary updates;
 - b. A statement describing how the rule complies with any applicable requirement under Wis. Stat. § 227.116;
 - c. The final EIA required under Wis. Stat. § 227.137(2);
 - d. The report of the Department of Administration if required under Wis. Stat. § 227.137(6);
 - e. Any energy impact report completed under Wis. Stat. § 227.117(2), and a statement describing the agency's consideration of the energy impact report in accordance with Wis. Stat. § 227.117(3);
 - f. The report of the Small Business Regulatory Review Board required under Wis. Stat. § 227.14(2g);
 - g. Any regulatory flexibility analysis completed under Wis. Stat. § 227.114;
 - h. A list of persons who appeared or registered for or against the rule at the hearing;
 - i. A summary of public comments to the proposed rule and the agency's response to those comments;
 - j. An explanation of any modifications made in the proposed rule as a result of public comments or testimony received at the public hearing; and
 - k. The Legislative Council Rule Clearinghouse report completed under Wis. Stat. § 227.15 and the agency's response to the report as required by Wis. Stat. § 227.19(3)(d).
3. For each emergency rule, the final draft rule submitted to the Governor's Office of Regulatory Compliance shall contain the following information:
 - a. A fiscal estimate in the format required by Wis. Stat. § 227.14(4); and

- b. A plain language analysis of the rule in the format required under Wis. Stat. § 227.14(2).
4. Following a review of the final draft rule, the Governor's Office of Regulatory Compliance shall notify the agency in writing whether the rule is approved or disapproved. A disapproval may be accompanied by suggested modifications. The agency may submit a revised rule for approval under the statement of scope that was previously approved by the Governor.



By the Governor:

Douglas La Follette
DOUGLAS LA FOLLETTE
Secretary of State

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Wisconsin to be affixed. Done at the Capitol in the City of Madison this second day of November, in the year two thousand eleven.

Scott Walker

SCOTT WALKER
Governor

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Chad Zadrazil, PDMP Project Manager		2) Date When Request Submitted: February 8, 2013 <small>Items will be considered late if submitted after 4:30 p.m. and less than:</small> <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: February 20, 2013	5) Attachments: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6) How should the item be titled on the agenda page? PDMP Update	
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 checked="" type="checkbox"/> Yes by Chad Zadrazil <small>(name)</small> <input type="checkbox"/> No	9) Name of Case Advisor(s), if required: N/A	
10) Describe the issue and action that should be addressed: I will give the Board an update on the Prescription Drug Monitoring Program (PDMP) and answer any questions from the members of the Board.			
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
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.			

Page intentionally left blank

**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: 2-8-13	
		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: February 20, 2013	5) Attachments: x Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Report from FSMB Conference “State Medical Licensure Discipline: Advocacy and Opportunities in 2013 and beyond” – Ft. Worth, TX – January 16, 17, 2013	
7) Place Item in: x 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: Sri Vasudevan and Tom Ryan will deliver reports from the January 16-17 FSMB meeting on portability.			
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	

Date: January 17, 2013

To: Sheldon Wasserman, MD
Chairman, Medical Examining Board

CC: Members of the Medical Examining Board

From: Sri Vasudevan, MD
Tom Ryan

Re: Report from the Meeting of the Federation of State Medical Boards (FSMB), "State Medical Licensure Discipline: Advocacy and Opportunities in 2013 and Beyond," held at the Westin DFW Airport Hotel, Irving, Texas, on January 16-17, 2013.

The meeting was called by FSMB to discuss "State Medical Licensure Discipline: Advocacy and opportunities from 2013 and beyond." The meeting was conducted on Wednesday, January 16, 2013 with registration 5:30 pm and meeting between 6 p.m. and 9 p.m. The meeting then continued on Thursday January 17, 2013 with breakfast at 7:30 am. and meeting from 8 a.m. concluding at 3 p.m.

Sri Vasudevan, MD, Member of the Medical Examining Board, and Tom Ryan, the Executive Director of the Medical Examining Board (MEB) attended the meeting, which was supported and approved by the members of the Medical Examining Board.

Background

The meeting was called with introductory remarks by Humayun Chaudhry, DO, President and Chief Executive Officer of the FSMB, located at 400 Fuller Wiser Road, in Euless, Texas. The goal was to have a "special meeting to explore medical licensure models."

Prior to the meeting, a FSMB policy brief in regards to "Licensure Models to Facilitate the Multistate Practice of Medicine" dated January 2013 was distributed. The material was classified as "Proprietary and confidential FSMB material—not for distribution."

A brief executive summary of this report indicates that on August 2012 the FSMB Advisory Council, a group comprised of Executive Directors of nine medical boards in United States met in Washington DC for ongoing discussions regarding the merit and feasibility of a common state medical licensure **portability model/s**, as proposed by the Maine Board of Licensure in Medicine at the 2012 FSMB annual meeting. The advisory council was tasked to review resolution 12-4, "establishment of platinum standard certification for Licensure for the purpose of multistate practice." This resolution did not pass, but was referred to the FSMB Board of Directors for study and a report back to the House of Delegates in 2013. The resolution would have charged member Boards with defining and developing a set criteria of qualifications for a "Platinum" Standard Certification for expedited interstate licensing along with a feasibility study of the Federation Credentials Verification System's ability to accommodate the new standard.

The meeting was convened mainly to also address "three prominent licensure portability models that are currently in use. These included:

- 1. Issuance of Telemedicine or special purpose license.**
- 2. Multistate practice by registration;**
- 3. Licensure by expedited endorsement.**

In the introduction to the topic, “Access to Care issues,” as well as “the expanding use and implementation of telemedicine and concerns about physician shortage” were described as resulting in mounting pressure on state licensing bodies to enable physician mobility.

It was also noted that with the soon to be implemented Affordable Care Act of 2010 nearly 30 million Americans would likely obtain health insurance and several changes in the way of delivering healthcare in the 21st century will occur rather rapidly.

It was noted that FSMB had developed the Federation Credentials Verification Service (FCVS) in 1996, which verifies and securely stores the physician’s core credentials until a retrieval of information is required for state licensure.

In addition it is noted that the FSMB’s Uniform Application (UA) is a newer tool that was developed to reduce licensure application and processing times through the use of an electronic application containing basic core information required by all state boards and a supplementary addendum for state specific queries and affirmation. Today 64 of the 69 boards with a licensing function accept or require the use of FCVS and 19 state boards are offering UA to physicians. Several additional states are in the process of considering their adoption.

Several models to address the main theme of multistate licensure were presented for discussion.

WEDNESDAY, JANUARY 16, 2013

Honorable James E. Geringer, Former Governor of Wyoming,

After the introduction, the former Governor of Wyoming, James Geringer, gave an excellent overview discussing "State Health Issues and Technology."

He noted that the goal to be addressed is "better health access and quality with lower costs." However, there is no single approach and there are several factors to consider. He observed that technology, telemedicine and portability of credentials are developing rapidly and "individuals are willing to be more personally responsible for their own health and there is increasing probability of federal, state and government intervention" in licensing decisions.

Governor Geringer then reviewed the concept of telemedicine, noting that it is “Mobile Technology.” He noted that “although the place of service is important, the location of the individual is more important.” An example was someone from Wyoming who goes to Mayo Clinic, Minnesota. The Minnesota physician does not have a license to practice in Wyoming, but when the patient returns back to Wyoming, they have to follow up with the physician at the Mayo Clinic, and that visit must be conducted via telemedicine.

He stated that in the prevailing licensure model, patient location is the point of care and not the location of the physician. He suggested that it may be helpful to characterize the point of care as the place where the interaction occurs.

However, he observed that there are few obstacles in implementing telemedicine and that the concept of telemedicine has “crystallized the tension between the state's role in protecting patients from incompetent physicians and protecting the in-state physician from out of state competition.”

He observed that state licensing Boards need to put aside their differences and create a uniform approach to the practice of medicine across state lines. If not, he warned "the federal government would have a cause to intervene." He opined that a “National license for practice of medicine is not an answer.” However, he observed that “multistate cooperation” with possible “memoranda of understanding” and “interstate compacts” may be some of the answers. Interstate compacts may offer some guidance, as they already occur situations such as nurse licensing, driver's licenses, and emergency management services.

He concluded that any new system must be simple, versatile, proven, and effective and it must improve cooperation in addressing this common problem so efficiency and effectiveness can be improved.

Some questions were offered regarding the complications of jurisdiction, including investigation and prosecution barriers, compliance with different state laws, and barriers to the exchange of information between states.

Michael P. Dugan, MBA

Mr. Dugan, the Chief Information Officer of the FSMB, discussed FSMB's activities and a timeline of FSMB activities toward achieving uniform standards in several areas including the development of the USMLE in 1995, the FCVS in 1996, the Model Practice Act in 1997, and the Common Licensing Application Form (CLAF) in 2004 which led to the development of the Uniform License Application (UA).

THURSDAY, JANUARY 17, 2013

The moderation, Hank Chaudhry, DO, observed the following:

1. There are three federal legislation initiatives that may negatively affect practice of medicine, two of which have been introduced as legislation;
2. A legislative initiative that has not been introduced as yet would be to create a “National License.”

Therefore, he suggested the need to be proactive.

First Panel discussion: Delivering healthcare: Today and tomorrow.

Mr. Jerry Klepner, FSMB

He noted that the Affordable Care Act will become law in January of 2014 and 30 million people will come into the system and will need access to care.

He identified three major issues:

1. The Federal Trade Commission (FTC) is challenging medical boards and state decisions regarding scope of practice (e.g., teeth whitening). The FTC has also created a fund of \$400 million annually for broadband access toward the development of “M-Medicine” (Modern Medicine). He noted that there are several other players including Intel, Verizon, Hewlett Packard, Bayer, Comcast, HCA, Canon, and IBM that are eager for increased use of telemedicine to occur very shortly.

2. He observed that Senator Udall recently created a “federal licensing structure,” and a bill may be introduced later this year. He noted that HR6719, authored by Rep. Mike Thompson, is in Committee. The bill concludes that “a physician needs to be licensed where he is physically located so he can practice telemedicine anywhere in the country.” This bill has already been scored (to determine the cause of the bill) so there is very high likelihood that this may advance this year.

3. President Obama is very interested in these issues as ACA will be implemented and more individuals will need access to healthcare.

He also observed that the Tenth Amendment, which is expected to protect states against interference from the Federal government, will not be sufficient for “this congress.” He noted that there are several mechanisms to “get around the Tenth Amendment.” He noted the role of reimbursement in motivating change, i.e., “If you want to get reimbursed you have to do this.”

Alexis Gilroy, GD, an attorney and partner at Nelson, Mullins, Reilly and Scarborough, LLP, Washington, DC

She noted that “The payer community is also very, very involved.” She observed that they moved from “smoke signals to remote surgery using robotics.” Information technology and its advancement have led to the creation of some standards and there is significant private investment and interest in this area as well as supportive legislation, and regulations are coming fast.

She again noted that “Telehealth is just a new method of doctors doing what they have already done, that is to provide care to patients.” She observed that collaboration between the primary care physician and specialist and patient can improve with telemedicine and technology.

Finally, she observed that through technology, safety and satisfaction will both improve. She also emphasized that “Our society is changing and we do not have to take patients to doctors, but doctors can see patients wherever they are” and finally concluded that the FSMB needs to make some changes now.”

Second Panel Discussion: Existing and Possible State-based Medical Licensure Models

The session was moderated by Mary Robinson, the Executive Director of Texas Medical Board.

Ralph Loomis, M.D., a neurosurgeon and Past President of the North Carolina Medical Board whose presentation was titled had an “Experiment of Licensure Application.” (EPLA).

Dr. Loomis discussed North Carolina’s experience with an expedited licensing system and estimated that by developing a “very high standard” for an expedited license, 20% (of 2,000 applicants) met the criteria for expedited processing.

Thomas Ryan, JD, MPA, Executive Director of the Wisconsin Medical Examining Board.

Mr. Ryan spoke about Wisconsin’s experience trying to improve portability of physician licensing in the midwest.

He discussed Wisconsin’s \$498,000 American Reinvestment and Recovery Act grant over the two-year period, 2010 to 2012. One goal was to move toward standardized licensing requirements and advance the concept of expedited endorsement, identifying the commonalities in state licensing requirements. He noted the challenges of reaching consensus among the states within the time period of the grant as well as the successes achieved. Nine jurisdictions cooperated, including Wisconsin, Minnesota, Iowa, Indiana,

Illinois, South Dakota, Missouri, Michigan (both allopathic and osteopathic Boards). A Declaration of Cooperation” was signed by four of these states.

This process also allowed the creation of an “online verification system,” designed to create efficiencies in the verification of licenses and improve the exchange of information about license applicants among states. The OVS is operational in Wisconsin and open for other Boards to join.

Randal Manning, MBA, Executive Director of the Maine Board of Licensure in Medicine

Mr. Manning noted that licensing is not a problem for a majority of the applicants. Originally, the Medical examining Board in the state of Maine had come up with a “platinum process.” He observed that it was incorrectly interpreted as a multistate vehicle. He noted that the process had determined the highest common denominator that one must meet to achieve the platinum standard.

He realized that a misunderstanding had led some to believe that they would obtain a specialized “platinum certificate.” He emphasized that creating a two-tiered licensing process was not intended.

The goal was to develop a centralized agency to process the applications, and that it was a voluntary system to simplify things, focus on access, and at the same time protect the public without offering this licensing route to the few physicians who should not be practicing. He stated alternative names may be needed.

Crady deGolian, director of the National Center for Interstate Compacts, the Council of State Government.

Mr. deGolian spoke gave an overview of his organization. He noted that interstate compacts are governed by contract law and have a constitutional origin, United States Article I, section X of the United States Constitution, clause I. Examples of such interstate compacts exist in these areas: State transportation, taxation, environmental matters, regulation, education, correctional systems, public safety, and the Great Lakes Compact.

He concluded that the benefits of interstate compacts include:

- A. Effectiveness and efficiency, as they can be less costly;
- B. Flexibility and autonomy;
- C. Agreed upon settlement among states;
- D. State and federal partnership, thus a collective venture;
- E. Cooperative behavior can lead to “win-win situations;”

Small Group Discussion:

There were several small group discussions at each table where there with 6 to 8 individuals at each table. Following the discussion, each table reported suggestions. The suggestions were quite varied.

The following are some of the main issues raised:

1. Interstate compacts should be explored further. Disciplinary action taken in any state would be applicable in all states. Both the state where the patient complaint occurred and where the physician’s main practice is would have jurisdiction, the responsibility to investigate, and the duty to share information (e.g., data sharing agreements, memoranda of understanding). How this might occur in practice, or if it would occur effectively, was not addressed in depth;

2. In the long-term, there is a need for more interstate cooperation with recognition that some applicants pose less of a risk and should benefit from expedited licensing (in this sense, “platinum”). For example, the initial application could be completed in the physician’s state of domicile and then when licensed, the member can credential in other states without re-verifying information that had already been verified and remains static. Benefits of this model include the possibility of a reduced fee charged by the non-domicile states, and more interstate practice. Among the disadvantages, it is noted, existing jurisdictional barriers and patient protections that may be useful could be eroded.
3. Many agreed that the level of qualification for the initial application needs to be high. It was eventually decided that “no precious metals such as gold, silver or platinum” will be used for description, but some type of higher standard than what currently exists will need to be agreed upon and should include board certification;
4. An expedited model of licensure that had been previously discussed was considered by many to be reasonable;
5. Some noted that “telemedicine” regulation should be technology/mode of care neutral and should not require a separate regulatory structure or credential.

At the conclusion of the meeting, the FSMB agreed to summarize all the information, then discuss it with the board of directors at their meeting next month. Outcomes from that meeting will be shared with each medical examining board for their input.

Some type of final action will be sought at the April 2013 Annual FSMB meeting in Boston.

Recommended action to the Wisconsin Medical Examination Board

1. Recommend that the Board wait for the FSMB report that will be shared with us by end of February and discuss this at our March meeting.
2. At the February or March meeting, the Wisconsin Medical Examining Board should discuss its opinions so that its representative can make appropriate comment at the FSMB meeting in Boston.

Page intentionally left blank

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Sheldon Wasserman		2) Date When Request Submitted:	
		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: January 16, 2013	5) Attachments: x Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Insurance Company Response to Board Discipline Orders	
7) Place Item in: x 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: Dr. Wasserman will lead this discussion.			
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	

Page intentionally left blank

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Dr. Wasserman		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: February 20, 2013	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Informational Item – Annals of Internal Medicine article, “Online Professionalism Investigations by State Medical Boards: First, Do No Harm”	
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: For informational purposes.			
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	

Online Professionalism Investigations by State Medical Boards: First, Do No Harm

S. Ryan Greysen, MD, MHS, MA; David Johnson, MA; Terry Kind, MD, MPH; Katherine C. Chretien, MD; Cary P. Gross, MD, MPH; Aaron Young, PhD; and Humayun J. Chaudhry, DO, MS, SM

Despite recent guidelines promoting online professionalism, consequences for specific violations by physicians have not been explored. In this article, the authors gauged consensus among state medical boards in the United States (response rate, 71%) about the likelihood of investigations for violations of online professionalism by using 10 hypothetical vignettes. *High consensus* was defined as more than 75% of respondents indicating that investigation was "likely" or "very likely," *moderate consensus* as 50% to 75% indicating this, and *low consensus* as fewer than 50% indicating this.

Four online vignettes demonstrated high consensus: Citing misleading information about clinical outcomes (81%; 39/48), using patient images without consent (79%; 38/48), misrepresenting credentials (77%; 37/48), and inappropriately contacting patients

(77%; 37/48). Three demonstrated moderate consensus for investigation: depicting alcohol intoxication (73%; 35/48), violating patient confidentiality (65%; 31/48), and using discriminatory speech (60%; 29/48). Three demonstrated low consensus: using derogatory speech toward patients (46%; 22/48), showing alcohol use without intoxication (40%; 19/48), and providing clinical narratives without violation of confidentiality (16%; 7/48).

Areas of high consensus suggest "online behaviors" that physicians should never engage in, whereas moderate- and low-consensus areas provide useful contextual information about "gray areas." Increased awareness of these specific behaviors may reduce investigations and improve online professionalism for physicians.

Ann Intern Med. 2013;158:124-130.

www.annals.org

For author affiliations, see end of text.

Since the earliest written codes of medical ethics, physicians have sworn to protect the public good with the maxim "first, do no harm" (1). Although this paradigm is traditionally applied to clinical actions, new technologies and reframing concepts of medical professionalism suggest a need to apply this principle more broadly (2). Ten years ago, policy from the Federation of State Medical Boards (FSMB) recognized the potential value of the Internet in health care delivery but cautioned that "physicians who provide medical care, electronically or otherwise, [should] maintain a high degree of professionalism" (3). Since then, the widespread public adoption of social networking and social media has created new challenges for physicians, who are expected to maintain high standards of professionalism when they are online (4-7). Studies of social media use by medical students and physicians have highlighted unprofessional online content in categories including depicted intoxication, sexually explicit material, conflicts of interest, and violations of patient privacy (8-10).

Previous research by our group has shown that 60% of U.S. medical school deans had concerns about students posting unprofessional content in these categories (11) and that 71% of U.S. state medical boards have investigated physicians for violations of professionalism online in 1 or more of these categories (12). To date, however, the likelihood of investigation for specific examples of violations in these categories has not been described.

The FSMB (13) and the American Medical Association (14, 15) have recently issued guidelines for maintaining professionalism when using social media; however, these guidelines do not address the range of likely professional consequences for specific violations. Therefore, we surveyed state medical boards in the United States to assess

levels of consensus about likely investigations for several online behaviors presented as hypothetical vignettes.

High consensus can show clear examples of "never" online behaviors for physicians to avoid, especially given known patterns of board actions for "offline" breaches of professionalism in such areas as violation of patient confidentiality, alcohol abuse, and inappropriate relationships with patients (16, 17). Low areas of consensus can drive further discussion to characterize context-dependent elements of "gray areas" that may constitute more serious breaches of professionalism and help physicians to recognize and avoid them. Moreover, the ease of posting user-generated content online through social media may amplify the consequences of lapses in professionalism (6, 18); increased awareness among physicians about specific examples of online unprofessional conduct explored in these vignettes can contribute to a more robust concept of online professionalism among physicians.

METHODS

Study Design and Sample

In partnership with the FSMB, we assessed consensus among the 70 state medical and osteopathic boards responsible for licensure and discipline of physicians in the United States about investigation for violations of online professionalism by using 10 hypothetical vignettes. Surveys were sent to the executive director of each board, and we encouraged them to consult with other key staff, such as investigators and board members, in formulating responses. Only 1 survey was collected from each board. This study was granted exemption by the Institutional Review Board for Yale University School of Medicine, New Haven, Connecticut.

Vignette Content

We developed a self-administered online survey instrument with items assessing board characteristics and responses to vignettes demonstrating specific violations of online professionalism. We defined "violations of online professionalism" on the basis of descriptions used in previous studies of Internet use and professionalism (6–12) and developed 10 vignettes with input from key informants to highlight online actions by physicians most likely to directly affect patients. These informants had experience as an executive director, board member, investigations unit manager, or senior legal counsel within a diverse, nationally representative sample of 10 state medical boards. Content for several vignettes was also drawn from actual incidents described in national media (19, 20). Key informants piloted the final version of the survey to ensure clarity and quality. We also piloted the survey with clinicians and researchers at 3 institutions (Yale University, George Washington University, and the FSMB) to ensure appropriateness of content and face validity.

For each vignette, respondents were asked to assume that the online content was openly accessible to the public and resulted in a complaint to their medical board. They were then asked to rate the likelihood of further investigation at their board in response to the content presented. Response choices used a 4-point incremental scale from "very unlikely" to "very likely," with an additional option for "don't know." Respondents also could provide free-text comments on each vignette after choosing from these responses.

Data Collection and Analysis

Officials from the FSMB invited the executive directors of all 70 boards to participate in the study through e-mail. In 2 states, a single executive director presides over both the allopathic and the osteopathic boards, so there were 68 potential respondents. Reminder e-mails were sent at 2, 4, and 6 weeks, and phone calls were made to non-responders after 8 weeks. Data collection took place between October 2010 and February 2011. No incentives were offered to complete the survey.

We analyzed the data with descriptive statistics and defined *high consensus* for investigation as more than 75% of respondents indicating "likely" or "very likely," *moderate consensus* as 50% to 75% indicating this, and *low consensus* as fewer than 50% indicating this. We viewed all respondents' free-text comments for each vignette and used negotiated consensus to choose illustrative quotations. The Appendix (available at www.annals.org) shows all comments, grouped by vignette.

RESULTS

Overall response rate to our survey was 71% (48/68), representing licensing boards from 38 of 50 states. These boards are collectively responsible for the medical licensure and discipline of 88% of the approximately 850 000 phy-

Table 1. State Medical Board Characteristics

Characteristic	Response Rate, % (n/N)
Licensee population	
≤5000	19 (9/48)
5000–9999	23 (11/48)
10 000–24 999	19 (9/48)
25 000–49 999	25 (12/48)
≥50 000	6 (3/48)
No response	8 (4/48)
Region	
Northeast	19 (9/48)
Midwest	15 (7/48)
South	40 (19/48)
West	27 (13/48)
Public board members*	
1 member	8 (4/48)
Several members comprising up to 25% of the board	46 (22/48)
Several members comprising 26%–50% of the board	29 (14/48)
None or not sure	6 (3/48)
Allow online reporting of complaints against physicians	
Yes	65 (31/48)
No or not sure	35 (17/48)
Have specific policies for Internet use by physicians	
Yes	23 (11/48)
No or not sure	77 (37/48)
Does the board use social media to communicate with physicians or patients?	
Yes	12 (6/48)
No or not sure	88 (42/48)
Overall level of concern about violations of online professionalism	
Not concerned at all	27 (13/48)
Moderately or very concerned	73 (35/48)

* Nonphysicians.

sicians with an active license in the United States in 2010 in jurisdictions populated by 273 million persons, or 89% of the U.S. population (21).

Most boards in our sample (65%; 31/48) allowed reporting of complaints through the Internet. Only 12% (6/48) of boards indicated that they used social media to communicate with licensees, patients, or other parties. Seventy-three percent (35/48) reported that their board was "moderately concerned" or "very concerned" overall about violations of online professionalism (Table 1).

Online Professionalism Vignettes

Four vignettes elicited high consensus for investigation. The vignette showing misleading claims of clinical results on a physician's practice Web site received the highest consensus for further investigation (81%; 39/48), followed closely by images of patients posted to a Web site without explicit consent (79%; 38/48) (Table 2). There was also strong consensus for investigation into misrepresentation of credentials on medical practice Web sites and

Table 2. Online Professionalism Vignettes and Likelihood of Board Investigation

Description	Rate of Respondents Indicating That Investigation Was "Likely" or "Very Likely," % (n/N)
High consensus*	
Misinformation on physician practice Web site	
Misleading claims of treatment outcomes	81 (39/48)
Misrepresentation of board certification	77 (37/48)
Patient confidentiality (online images)	
Images of patient posted to Web site without explicit consent	79 (38/48)
Inappropriate communication with patients	
Use of online dating site (SNS) to "chat" with patient	77 (37/48)
Moderate consensus†	
Depicted alcohol intoxication online	
Image of physician intoxicated with alcohol posted to SNS	73 (35/48)
Patient confidentiality (narrative descriptions online)	
Narrative (blog) of patient encounter with potential identifiers	65 (31/48)
Discriminatory speech online	
Narrative expressing discrimination posted to SNS	60 (29/48)
Low consensus‡	
Derogatory speech online	
Narrative (blog) expressing disrespect for patients	46 (22/48)
Depicted use of alcohol without intoxication online	
Image of physicians holding alcoholic beverages posted to SNS	40 (19/48)
Patient confidentiality (narrative descriptions online)	
Narrative (blog) of patient encounter with no identifiers	16 (7/48)

SNS = social networking site (for example, Facebook, Myspace, Match.com).

* >75% of respondents indicated that investigation was "likely" or "very likely."

† 50%–75% of respondents indicated that investigation was "likely" or "very likely."

‡ <50% of respondents indicated that investigation was "likely" or "very likely."

use of an online dating site to interact with a patient (each at 77%; 37/48). **Figure 1** shows specific content from the high-consensus vignettes.

Responses to 3 vignettes showed moderate consensus for investigation. The vignette depicting alcohol use with implied intoxication received the highest consensus for investigation within this subset (73%; 35/48) (Table 2). Five respondents clarified their response to this vignette with a free-text comment (Appendix). One stated, "We would need more information before deciding how to handle this report," and 2 respondents indicated specific context that might change their response: "Depends upon past issues with the Board" and "Unless one of the licensees was on probation or under investigation involving alcohol or substance abuse, etc."

Sixty-five percent (31/48) of respondents indicated that investigation was likely for the vignette demonstrating

violation of patient confidentiality through online narrative description, and 60% (29/48) indicated that investigation was likely for the vignette depicting discriminatory speech toward patients online (Table 2). For the latter vignette, 2 respondents clarified their responses of "unlikely" with free-text comments: "Unlikely unless it appeared the physician deviated from the standard of care due to these beliefs" and "I say unlikely not because I don't think he deserves to be disciplined, but this is probably a case that the Attorney General's Office would never bring before us" (Appendix). **Figure 2** shows specific content from the moderate-consensus vignettes.

Responses to 3 vignettes demonstrated low consensus for investigation. The vignette depicting derogatory speech

Figure 1. Vignettes with high consensus for investigation.

Misinformation on Practice Web Sites

Misleading claims: The daughter of a patient with cancer contacts your board about statements made by her mother's physician on his practice Web site. She claims that the physician misled her mother about the potential benefits of his treatment plan. On the physician's practice Web site, you discover such claims as "I can cure your cancer—guaranteed!"

Misrepresented credentials: A concerned hospital administrator contacts your board about credentials of a physician requesting privileges at his hospital. He reports that the physician's practice Web site claims that the physician is "board-certified in pediatrics" even though he does not list completion of a residency in pediatrics among his credentials. You decide to check and discover that he is *not* a diplomat of any specialty board.

Patient Confidentiality—Online Images

A patient reports that images of her labor and delivery were posted on her obstetrician's practice Web site (in educational materials for other patients) without her consent:



Inappropriate Communication With Patients Online

A concerned patient reports possibly inappropriate contact initiated by her physician through a "chat" feature of an online dating site:

Doc1971: Hi there, remember me? I took care of you at Frankenstein Memorial a few weeks ago.
 SuzieQ: Oh, hi—of course I remember you!
 Doc1971: Well, we don't need to wait for your follow-up appointment to see each other again. What are you doing this weekend? Want to meet up for a drink?

More than 75% of respondents indicated that investigation was "likely" or "very likely." Photograph on the left ©iStockphoto.com/ryangreysen; photograph on the right courtesy of Dr. Greysen.

toward patients online received the highest consensus for investigation within this subset (46%; 22/48) (Table 2). One respondent added a comment for this vignette suggesting a noninvestigational response to the violation: "Possibly private letter of concern that this activity is risky and could go over the line at some point, and instruct the physician that he/she needs to be very careful as it could backfire" (Appendix).

Only 40% (19/48) of respondents indicated that investigation was likely for the vignette depicting alcohol use online without intoxication, yet this vignette received the highest number of free-text comments among all vignettes. Several respondents indicated specific context that might change their response; 3 specifically referenced concerns about drinking in the context of active patient care duties: "Unlikely unless it appeared alcohol use interfered with the safe practice of medicine"; "We would just want to ensure the physician wasn't returning to work after drinking at the party"; and "Issue not drinking but drinking while practicing in office while dressed with medical garb." In addition, 1 respondent added specific context outside the scope of patient care that would influence the board's response: "Unless there were other incidents (driving under the influence of alcohol, for example), which would make this more than just a social event at which she may have had a drink."

Finally, the vignette showing an online narrative description without a violation of patient confidentiality had the lowest consensus for investigation of all of the vignettes (16%; 7/48) (Table 2) and elicited only 1 comment: "We would need more information before deciding how to handle this report" (Appendix). Figure 3 shows specific content from the low-consensus vignettes.

To better characterize this information, we also assessed outlier boards. Three respondents (6%) indicated that the board was either "likely" or "very likely" to investigate each of the 10 vignettes; one of these provided additional clarification in a comment: "Board policy is to open and investigate all complaints received." One respondent indicated "don't know" for all 10 vignettes and added this comment after each vignette: "Would be referred to Professional Compliance Office." No boards responded that they were either "unlikely" or "very unlikely" to investigate all 10 vignettes.

DISCUSSION

This national survey of state medical boards shows high consensus about probable investigation for certain online behaviors. We present evidence that most boards are likely to investigate reports of online misinformation, inappropriate communication with patients, and posting of patient images without consent. Of note, these violations clearly parallel common offline violations, as well as established statutory (22, 23) and professional codes (24) that

Figure 2. Vignettes with moderate consensus for investigation.

Depicted Alcohol Intoxication Online

A concerned patient reports that her physician frequently describes "partying" on his MySpace page, accompanied by images of himself intoxicated, such as the one below:



Patient Confidentiality—Narrative Descriptions Online

Use of potential identifiers: A concerned patient reports content on a physician's blog describing clinical encounters:

"Yesterday, I saw my patient Mr. S, a silver-haired man in his 40s who complained of burning urination. After further questioning, it turns out Mr. S has been having an affair, but, unfortunately, he would not consent to HIV testing. This really frustrates me as a physician because Mr. S is a health care worker in our hospital, so both his wife and our patients could be affected by his HIV status."

Discriminatory Speech Online

A concerned staff member at a local hospital reports discriminatory language on a physician's Facebook page:

"I saw this homosexual patient who came in complaining of dysuria and wants me to help. Well...that's what you get for being gay. I really don't feel any compassion for these people—they don't deserve antibiotics, they need to change their behaviors."

50% to 75% of respondents indicated that investigation was "likely" or "very likely." Photograph courtesy of Dr. Greysen.

may provide licensing boards with the highest clarity for action.

Our findings provide specific examples of online behaviors that should be considered "never" behaviors for physicians to maintain expected levels of professionalism online and avoid possible investigation by state medical boards. Although the avoidance of such behaviors alone is certainly not sufficient to attain the high levels of professionalism expected from physicians, our approach helps to apply the Hippocratic tradition of "first, do no harm" to the online environment.

We also found that likelihood of investigation in "gray areas," such as posting narratives about clinical encounters, derogatory speech, and alcohol use, varied depending on context. Physicians who post narratives about patients with potential identifiers risk investigation, but our data also

Figure 3. Vignettes with low consensus for investigation**Derogatory Speech Online**

A concerned patient reports disrespectful language on a physician's blog:

"I can't believe how stupid my patients are sometimes. For example, I saw this guy—a real jerk—who keeps coming back to the ER over and over again with high blood sugar levels. He refuses to take his insulin, watch his diet, or take care of himself. I guess he feels entitled to emergency care at someone else's expense just because he's lazy and ignorant. In the last month, he's been to the emergency room EIGHT times, which has led to FIVE inpatient admissions. How stupid can you be? And the worst part is, I know he'll be back next week with the same problem and I'll have to smile and go through the same motions with him!"

Depicted Use of Alcohol Without Intoxication Online

A concerned patient reports that her surgeon posted pictures of herself drinking at a hospital holiday party on Facebook:

**Patient Confidentiality—Narrative Descriptions Online**

No potential identifiers: A concerned patient reports content on a physician's blog describing clinical encounters:

"Sometimes I see patients who make decisions that can adversely affect both their health and the health of others. For example, I saw a patient once who was concerned about STDs but would not consent to HIV testing. He was married and also a health care worker, so his decision to refuse testing frustrated me as a physician."

Fewer than 50% of respondents indicated that investigation was "likely" or "very likely." Photograph courtesy of Dr. Greysen.

provide reassurance that licensing authorities are unlikely to investigate narratives of patient encounters with meticulous attention to protecting confidentiality. Some have argued that an even higher standard could include sharing such narratives with the patients described and obtaining their assent before posting the material online (25, 26). In cases where this is impractical, physicians could seek advice from colleagues before posting patient narratives online.

In a similar manner, although derogatory or discriminatory speech seems less likely to provoke investigation by medical boards than more egregious or "never" behaviors, new policy on social media use issued by the FSMB in 2012 clearly indicates that state boards have the authority to discipline physicians for the use of social media to make

derogatory or discriminatory remarks about patients (13). Moreover, broader principles for medical professionalism, such as altruism and the primacy of patient welfare (2), would suggest that the best practice for physicians is to avoid this behavior altogether.

Finally, our data suggest that online images of physicians consuming alcohol where intoxication is not implied are unlikely to draw unwanted attention from boards, provided that there are no other "red flags," such as evidence of drinking while on duty or an established history of alcohol or substance misuse. This finding is consistent with the general stance of medical boards toward alcohol use; boards are most concerned about the use of alcohol when it endangers the public or is problematic as manifested by patterns of abuse (for example, dependence or alcoholism) (27).

These gray areas collectively suggest a need to expand the current dialogue about online professionalism to create standards with even broad consensus about what is or is not appropriate online behavior for physicians that parallel standards for offline professional behavior.

Our findings build on previous studies of social media use among health care professionals (8–12, 28, 29) and have particular relevance for shaping future practice. Recent data show that unprofessional use of the Internet does not cease once medical students graduate, and although there may still be a generational effect for social media use, recent trends show increased use among age groups mirroring the demographic characteristics of most licensed physicians (30).

Beyond the potential for board investigation, there may be other legal consequences for violations of online professionalism as depicted in our vignettes, especially if these trends continue. Hospitals may suspend or terminate privileges; employers may terminate employment and could even bring suit against physicians for negative publicity as a consequence of unprofessional content posted by physicians. Likewise, patients could bring suit for violations of privacy under the Health Insurance Portability and Accountability Act that could also be prosecuted by the Department of Health and Human Services.

Finally, as more patients and practicing physicians use social media, greater awareness of potential pitfalls among both parties will be essential to ensuring high standards for online professionalism among physicians and appropriate interactions between patients and physicians online. Indeed, several studies have suggested that such social networking interactions as "friending" between patients and their physicians may be inappropriate (31, 32), and guidelines by the FSMB and American Medical Association provide specific guidance on maintaining a separate professional online presence and limiting public access to physicians' personal online presence (13, 14).

Our study has several limitations. Our vignettes were hypothetical and asked respondents to indicate the likeli-

hood of further investigation; they were not asked to speculate what disciplinary outcomes might occur as a result of investigation. Although we developed our vignettes on the basis of current literature, media reports of actual violations, and extensive input from key informants, we were not able to capture all possible violations of online professionalism and our survey instrument was not validated in an external sample.

Although our response rate was high (71%), there may be response bias toward boards with experiences of physician violations of online professionalism and reactions to these violations may differ among nonresponding boards. There was no substantial variation in responses by region, and we did not receive responses from any of the 4 U.S. territories (Puerto Rico, Guam, the U.S. Virgin Islands, and the Northern Mariana Islands). Finally, in some states, the attorney general's office or a similar entity investigates claims received by the medical board rather than the board itself. Some boards accordingly may believe that certain violations merit investigation but would probably not be investigated on the basis of the priorities of these entities. Although we did not survey persons at these entities directly, we instructed respondents to discuss the study vignettes with these persons or other key staff if they believed it was necessary or beneficial to formulate their responses about likely investigation.

In conclusion, we found a high degree of consensus among state medical boards about the likelihood of investigation for certain online behaviors, whereas consensus in other areas was lower and more dependent on context. Physicians should be aware of the potential consequences for online behaviors as depicted in these vignettes and apply the same high ethical and professional standards in their online actions as they would in their actions offline. Our findings underscore the need for more continuing education of physicians in practice about potential interpretations and consequences of online actions so that their social media presence can be a professional benefit instead of a liability.

From the University of California, San Francisco, School of Medicine, San Francisco, California; Federation of State Medical Boards, Eules, Texas; Children's National Medical Center, George Washington University School of Medicine, and Washington DC Veterans Affairs Medical Center, Washington, DC; Yale University School of Medicine, New Haven, Connecticut; and University of Texas Southwestern Medical School, Dallas, Texas.

Disclaimer: Dr. Greysen had full access to all of the data in the study and takes responsibility for their integrity and the accuracy of the data analysis.

Acknowledgment: The authors thank the Robert Wood Johnson Foundation Clinical Scholars program and the Department of Veterans Affairs for support of this research. They also thank the key informants at state medical boards and the FSMB for their valuable insight into the structure and function of state medical and osteopathic boards.

Potential Conflicts of Interest: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M12-1641.

Requests for Single Reprints: S. Ryan Greysen, MD, MHS, MA, Division of Hospital Medicine, University of California, San Francisco, 533 Parnassus Avenue, Box 0131, San Francisco, CA 94113; e-mail, Ryan.Greysen@ucsf.edu.

Current author addresses and author contributions are available at www.annals.org.

References

- Edelstein L. The Hippocratic Oath: Text, Translation, and Interpretation. Supplements to the Bulletin of the History of Medicine. vol.1. Baltimore: Johns Hopkins Univ Pr; 1943.
- ABIM Foundation. American Board of Internal Medicine. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med.* 2002; 136:243-6. [PMID: 11827500]
- Federation of State Medical Boards. Model Guidelines for the Appropriate Use of the Internet in Medical Practice. Dallas, TX: Federation of State Medical Boards; 2002. Accessed at www.fsmb.org/pdf/2002_grpol_Use_of_Internet.pdf on 19 August 2012.
- Guseh JS 2nd, Brendel RW, Brendel DH. Medical professionalism in the age of online social networking. *J Med Ethics.* 2009;35:584-6. [PMID: 19717700]
- Jain SH. Practicing medicine in the age of Facebook. *N Engl J Med.* 2009; 361:649-51. [PMID: 19675328]
- Greysen SR, Kind T, Chretien KC. Online professionalism and the mirror of social media. *J Gen Intern Med.* 2010;25:1227-9. [PMID: 20632121]
- Mostaghimi A, Crotty BH. Professionalism in the digital age. *Ann Intern Med.* 2011;154:560-2. [PMID: 21502653]
- Thompson LA, Dawson K, Ferdig R, Black EW, Boyer J, Coutts J, et al. The intersection of online social networking with medical professionalism. *J Gen Intern Med.* 2008;23:954-7. [PMID: 18612723]
- Lagu T, Kaufman EJ, Asch DA, Armstrong K. Content of weblogs written by health professionals. *J Gen Intern Med.* 2008;23:1642-6. [PMID: 18649110]
- Chretien KC, Azar J, Kind T. Physicians on Twitter. *JAMA.* 2011;305: 566-8. [PMID: 21304081]
- Chretien KC, Greysen SR, Chretien JP, Kind T. Online posting of unprofessional content by medical students. *JAMA.* 2009;302:1309-15. [PMID: 19773566]
- Greysen SR, Chretien KC, Kind T, Young A, Gross CP. Physician violations of online professionalism and disciplinary actions: a national survey of state medical boards. *JAMA.* 2012;307:1141-2. [PMID: 22436951]
- Federation of State Medical Boards. Model Policy Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice. Accessed at www.fsmb.org/pdf/pub-social-media-guidelines.pdf on 25 November 2012.
- American Medical Association. AMA Policy: Professionalism in the Use of Social Media. Accessed at www.ama-assn.org/ama/pub/meeting/professionalism-social-media.shtml on 19 August 2012.
- Shore R, Halsey J, Shah K, Crigger BJ, Douglas SP; AMA Council on Ethical and Judicial Affairs (CEJA). Report of the AMA Council on Ethical and Judicial Affairs: professionalism in the use of social media. *J Clin Ethics.* 2011; 22:165-72. [PMID: 21837888]
- Morrison J, Wickersham P. Physicians disciplined by a state medical board. *JAMA.* 1998;279:1889-93. [PMID: 9634260]
- Khaliq AA, Dimassi H, Huang CY, Narine L, Smego RA Jr. Disciplinary action against physicians: who is likely to get disciplined? *Am J Med.* 2005;118: 773-7. [PMID: 15989912]
- Suler J. The online disinhibition effect. *Cyberpsychol Behav.* 2004;7:321-6. [PMID: 15257832]
- Page ES. State investigates patient info shared on Facebook. *NBC News.* 8 June 2010. Accessed at www.nbcсандiego.com/news/health/State-Confirms-Tri-City-Investigation-95467764.html on 19 August 2012.

20. CNN.com. Photos of drinking, grinning aid mission doctors cause uproar. 29 January 2010. Accessed at http://articles.cnn.com/2010-01-29/world/haiti.puerto.rico.doctors_1_doctors-hippocratic-oath-primera-hora-newspaper?_s=PM:WORLD on 19 August 2012.
21. Young A, Chaudhry H, Rhyne J, Dugan M. A census of actively licensed physicians in the United States in 2010. *Journal of Medical Regulation*. 2011;96:10-20. Accessed at www.fsmb.org/pdf/census.pdf on 3 December 2012.
22. Federation of State Medical Boards. *Essentials of a Modern Medical and Osteopathic Practice Act*. 12th ed. Dallas, TX: Federation of State Medical Boards; 2012. Accessed at www.fsmb.org/pdf/GRPOL_essentials.pdf on 19 August 2012.
23. Federation of State Medical Boards. *Addressing Sexual Boundaries: Guidelines for State Medical Boards*. Accessed at www.fsmb.org/pdf/GRPOL_Sexual%20Boundaries.pdf on 19 August 2012.
24. American Medical Association. *AMA Code of Medical Ethics*. 2001. Accessed at www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page on 19 August 2012.
25. Lagu T, Greysen SR. Physician, monitor thyself: professionalism and accountability in the use of social media. *J Clin Ethics*. 2011;22:187-90. [PMID: 21837893]
26. Herrin B, Ingram T. PHI faux pas: social media and the unauthorized disclosure of PHI. *J Med Pract Manage*. 2012;27:275-6. [PMID: 22594058]
27. Federation of State Medical Boards. *Policy on Physician Impairment from the Federation of State Medical Boards of the United States, Inc.* 2011. Accessed at www.fsmb.org/pdf/jmr-phy-imp-policy.pdf on 19 August 2012.
28. Thompson LA, Black E, Duff WP, Paradise Black N, Saliba H, Dawson K. Protected health information on social networking sites: ethical and legal considerations. *J Med Internet Res*. 2011;13:e8. [PMID: 21247862]
29. Farnan JM, Higa J, Paro J, Reddy S, Humphrey HJ, Arora VM. Usage and perceptions of policy regarding digital media among medical trainees. *Am J Bioethics: Primary Research*. 2010;1:3-10.
30. Lenhart A. *Adults and Social Network Websites*. Pew Internet & American Life Project. 14 January 2009. Accessed at www.pewinternet.org/Reports/2009/Adults-and-Social-Network-Websites.aspx on 19 August 2012.
31. Kind T, Greysen SR, Chretien KC. Pediatric clerkship directors' social networking use and perceptions of online professionalism. *Acad Pediatr*. 2012;12:142-8. [PMID: 22306287]
32. Chretien KC, Farnan JM, Greysen SR, Kind T. To friend or not to friend? Social networking and faculty perceptions of online professionalism. *Acad Med*. 2011;86:1545-50. [PMID: 22030752]

ACP JOURNAL CLUB

ACP Journal Club summarizes the best new evidence for internal medicine from over 130 clinical journals. Once a bimonthly stand-alone journal, *ACP Journal Club* now appears in the pages of *Annals* on a monthly basis. Research staff and clinical editors rigorously assess the scientific merit of the medical literature as it is published, and a worldwide panel of over 5000 physicians assesses the clinical relevance and newsworthiness of rigorous studies.

Look for *ACP Journal Club* in *Annals*, or visit www.annals.org/journalclub.aspx.

Current Author Addresses: Dr. Greysen: Division of Hospital Medicine, University of California, San Francisco, 533 Parnassus Avenue, Box 0131, San Francisco, CA 94113.

Mr. Johnson and Drs. Young and Chaudhry: Federation of State Medical Boards, 400 Fuller Wisser Road, Suite 300, Euless, TX 76039.

Dr. Kind: Children's National Medical Center, 111 Michigan Ave NW, Washington, DC 20010.

Dr. Chretien: 11220 Upton Drive, Kensington, MD 20895.

Dr. Gross: Yale University School of Medicine, 333 Cedar Street, Box 208093, New Haven, CT 06520-8093.

Author Contributions: Conception and design: S.R. Greysen, D. Johnson, T. Kind, K.C. Chretien, C.P. Gross, A. Young, H.J. Chaudhry. Analysis and interpretation of the data: S.R. Greysen, D. Johnson, T. Kind.

Drafting of the article: S.R. Greysen, K.C. Chretien.

Critical revision of the article for important intellectual content: S.R. Greysen, D. Johnson, T. Kind, K.C. Chretien, C.P. Gross, A. Young, H.J. Chaudhry.

Final approval of the article: S.R. Greysen, D. Johnson, T. Kind, K.C. Chretien, C.P. Gross, A. Young, H.J. Chaudhry.

Administrative, technical, or logistic support: C.P. Gross, A. Young, H.J. Chaudhry.

Collection and assembly of data: S.R. Greysen, A. Young, H.J. Chaudhry.

APPENDIX: SPECIFIC COMMENTS, BY VIGNETTE Vignettes With High Consensus for Investigation Misinformation on Practice Web Site

Misrepresentation of Board Certification on Physician Practice Web Site. "This is a big issue in [our state] and would be dealt with."

"Fraudulent advertising by a physician is grounds for discipline in our state."

"We are currently reviewing several doctors for this very thing, claiming they are board-certified when they are not."

Misleading Claims of Treatment Outcomes on Physician Practice Web Site. "It's possible this would receive scrutiny. We'd want more contextual information before reacting."

Patient Confidentiality (Online Images): Images of Patient Posted to Web Site Without Explicit Consent

"In [our state], each complaint is reviewed on an individual basis and the facts of each specific complaint are considered in making the determination of whether a legally sufficient complaint has been made and an investigation opened."

"We would need more information before deciding how to handle this report."

"If patient privacy is violated, the Board investigates."

Inappropriate Communication With Patients: Use of Online Dating Site (Social Networking Site) to "Chat" With Patient

"We would need more information before deciding how to handle this report."

"Because she is still a patient, apparently, by the use of the phrase 'follow-up.'"

Vignettes With Moderate Consensus for Investigation Depicted Alcohol Intoxication Online: Image of Physician Intoxicated With Alcohol Posted to SNS

"Unless one of the licensees was on probation or under investigation involving alcohol or substance abuse, etc."

"We would need more information before deciding how to handle this report."

"Significant evidence to open a case to determine ability to practice safely."

"Depends upon past issues with the Board."

"Probable referral to the physician health program."

Patient Confidentiality (Narrative Descriptions Online): Narrative (Blog) of Patient Encounter With Potential Identifiers

"In [our state], each complaint is reviewed on an individual basis and the facts of each specific complaint are considered in making the determination of whether a legally sufficient complaint has been made and an investigation opened."

"We would need more information before deciding how to handle this report."

Discriminatory Speech Online: Narrative Expressing Discrimination Posted to Social Networking Site

"I say unlikely not because I don't think he deserves to be disciplined, but this is probably a case that the Attorney General's Office would never bring before us."

"Unlikely unless it appeared the physician deviated from the standard of care due to these beliefs."

Vignettes With Low Consensus for Investigation Derogatory Speech Online: Narrative (Blog) Expressing Disrespect for Patients

"I say unlikely not because I don't think he deserves to be disciplined, but this is probably a case that the Attorney General's Office would never bring before us."

"Possibly private letter of concern that this activity is risky and could go over the line at some point, and instruct the physician that he/she needs to be very careful as it could backfire."

Depicted Use of Alcohol Without Intoxication Online: Image of Physicians Holding Alcoholic Beverages Posted to Social Networking Site

"Unlikely unless it appeared alcohol use interfered with the safe practice of medicine."

"Unless one of the licensees was on probation or under investigation involving alcohol or substance abuse, etc."

"Issue not drinking but drinking while practicing in office while dressed with medical garb."

"Look at the state medical society newsletters. They're full of such photographs."

"Unless there were other incidents (driving under the influence, for example), which would make this more than just a social event at which she may have had a drink."

"Not a violation of the Medical Practice Act to drink alcohol."

"Depends upon past issues with the Board."

“Professionals need to be VERY careful what they allow to be posted.”

“We would just want to ensure the physician wasn’t returning to work after drinking at the party.”

“We would need more information before deciding how to handle this report.”

“Though we likely would contact the physician and counsel him/her.”

“Again, perhaps same as in certain cases above, investigate if this is a repeated activity. Certainly is bad public relations for a physician.”

“We would need more information before deciding how to handle this report.”

“Would normally result in an advisory letter.”

Patient Confidentiality (Narrative Descriptions): Narrative (Blog) of Patient Encounter With No Identifiers

“We would need more information before deciding how to handle this report.”

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Sandy Nowack, Attorney Steve Engelbrecht, Paralegal (1-4483)	2) Date When Request Submitted: Jan. 29, 2013
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: Feb. 20, 2013	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Introduction of MED/HEALTH Team Division of Legal Services and Compliance
--	--	---

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? <input checked="" type="checkbox"/> Yes (<u>Fill out Board Appearance Request</u>) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required: N/A
--	---	--

10) Describe the issue and action that should be addressed:

 Lead Attorney of the MED/HEALTH Team, Sandy Nowack, will introduce the newly formed MED/HEALTH Team.

11) Authorization

	Jan. 29, 2013
Signature of person making this request	Date
Supervisor (if required)	Date
Executive Director signature (indicates approval to add post agenda deadline item to agenda)	Date

Directions for including supporting documents:

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 Policy Development Executive Director.
3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.

Page intentionally left blank