



MEDICAL EXAMINING BOARD
Room 121A, 1400 East Washington Avenue, Madison
Contact: Tom Ryan (608) 266-2112
February 19, 2014

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

AGENDA

8:00 A.M.

OPEN SESSION – CALL TO ORDER – ROLL CALL

A) Adoption of Agenda

B) Welcome New Members

C) Approval of Minutes of January 15, 2014 (5-12)

D) Appointments/Reappointments

- 1) Dr. Mary Jo Capodice **(13-14)**
- 2) Dr. Kenneth Simons **(15-16)**

E) Administrative Updates

- 1) Staff Updates
- 2) Rules Liaison
- 3) Delegated Authority Motion **(17-18)**
- 4) Delegation of Scheduling of Screening Panel Members and Examiners to DSPS Staff – Discussion and Consideration

F) Presentation of Petitions for Summary Suspension

- 1) Ronald G. Rubin MD – 13 MED 039 **(443-482)**
 - a) **8:05 A.M. – APPEARANCE** – Arthur Thexton, DLSC Attorney

G) Prescription Drug Monitoring Program (PDMP) Update (19-20)

- 1) **APPEARANCE** – Chad Zadrazil, PDMP Program Director
- 2) PDMP Liaison Appointment – Discussion and Consideration

- H) Legislative/Administrative Rule Matters:**
- 1) Current and Future Rule Making and Legislative Initiatives
 - 2) Administrative Rules Report
 - 3) Discussion of 2013 Assembly Bill 742, Relating to Licensure of Physicians; Providing an Exemption from Emergency Rule Procedures; and Granting Rule-Making Authority **(21-42)**
 - 4) 165-Med 13.03, CE Audit Proposed Rule **(43-48)**
 - 5) 2009 Wisconsin Act 382 and MED 5.04 **(49-54)**
 - 6) Scope Statement for MED 18.03, Relating to Informed Consent **(55-58)**
- I) Federation of State Medical Boards (FSMB) Matters – Discussion and Consideration**
- 1) Minimum Data Set (MDS) Pilot Implementation Project **(59-84)**
 - a) **8:30 A.M. – APPEARANCE** – Aaron Young, FSMB
 - 2) FSMB Report of the Special Committee on Physician Re-Entry into Practice **(85-122)**
 - 3) Other
- J) Speaking Engagement(s), Travel, or Public Relation Request(s)**
- 1) Request for Dr. Swan to Appear before the Fond du Lac County Medical Society on February 27, 2014 to Discuss MED 10. **(123-124)**
- K) Licensing Committee Report**
- L) Disciplinary Guidelines Committee Report**
- M) Screening Panel Report**
- N) Items Added After Preparation of Agenda:**
- 1) Introductions, Announcements and Recognition
 - 2) Administrative Updates
 - 3) Education and Examination Matters
 - 4) Credentialing Matters
 - 5) Practice Matters
 - 6) Legislation/Administrative Rule Matters
 - 7) Liaison Report(s)
 - 8) Informational Item(s)
 - 9) Disciplinary Matters
 - 10) Presentations of Petition(s) for Summary Suspension
 - 11) Presentation of Proposed Stipulation(s), Final Decision(s) and Order(s)
 - 12) Presentation of Proposed Decisions
 - 13) Presentation of Interim Order(s)
 - 14) Petitions for Re-Hearing
 - 15) Petitions for Assessments
 - 16) Petitions to Vacate Order(s)
 - 17) Petitions for Designation of Hearing Examiner
 - 18) Motions
 - 19) Petitions
 - 20) Appearances from Requests Received or Renewed
 - 21) Speaking Engagement(s), Travel, or Public Relation Request(s)
- O) Public Comments**

CONVENE TO CLOSED SESSION to deliberate on cases following hearing (s. 19.85(1)(a), Stats.); to consider licensure or certification of individuals (s. 19.85(1)(b), Stats.); to consider closing disciplinary investigations with administrative warnings (ss. 19.85 (1)(b), and 448.02(8), 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.).

P) Full Board Oral Examination of Candidates for Licensure:

- 1) **9:40 A.M. – APPEARANCE – Zaki A. Qureshi, M.D. (125-184)**

Q) Presentation and Deliberation of Proposed Stipulations, Final Decisions, and Orders:

- 1) Cha Lee, M.D. – 11 MED 232 **(185-192)**
 - a) **9:50 A.M. – APPEARANCE – Robert Dvorak, Attorney for Cha Lee, M.D**
- 2) H.S. Ashraf, M.D. – 12 MED 282 **(193-198)**
- 3) Harold H. Randecker, Jr., M.D. – 13 MED 034 **(199-204)**

R) Presentation and Deliberation of Proposed Decision and Order in the Matter of the Application for Nipa H. Sinh, M.D., DHA Case No. SPS-13-0049; DLSC Case No. 13 MED 398 (205-218)

- 1) **10:00 A.M. – APPEARANCE – Patricia J. Epstein, Attorney for Nipa H. Sinh**
- 2) **10:00 A.M. – APPEARANCE – Arthur Thexton, DLSC Attorney**

S) Monitoring Matters

- 1) **10:10 A.M. – APPEARANCE – Terrance Moe – Requesting Full License (221-288)**
- 2) Amy Coulthard-Atwater – Requesting Full License (Completed Requirements) **(289-298)**
- 3) Gope Hotchandani – Requesting Full License (Completed Requirements) **(299-320)**
- 4) William B. Lyles – Requesting an Extension of Time to Pay Costs and Complete CE's **(321-338)**
- 5) Javier A. Rincon – Requesting Limitation Be Removed **(339-354)**
- 6) Charles E. Nelson – Requesting Full License **(355-374)**
- 7) Lawrence J. Williamson – Requesting Permission to Reapply for License **(375-394)**

T) Deliberation on Petitions for Summary Suspension

- 1) Ronald G. Rubin MD – 13 MED 039 **(443-482)**

U) Presentation and Deliberation on Administrative Warnings

- 1) 12 MED 353 (D.I.S.) **(395-396)**
- 2) 13 MED 165 (M.R.A.) **(397-398)**
- 3) 13 MED 263 (A.J.S.) **(399-400)**
- 4) 13 MED 302 (T.S.O.) **(401-402)**
- 5) 13 MED 342 (J.K.T.) **(403-404)**
- 6) 13 MED 345 (M.C.C.) **(405-406)**

V) Presentation and Deliberation of Complaints for Determination of Probable Cause

- 1) 12 MED 239 – John P. Christensen, M.D. **(407-410)**

W) Case Status Report (411-416)

X) Case Closing(s)

- 1) 12 MED 219 (A.M.C. and G.P.) **(417-426)**
- 2) 13 MED 287 (K.H.M.) **(427-430)**
- 3) 13 MED 377 (I.A.) **(431-434)**
- 4) 13 MED 378 (R.J. and R.N.) **(435-442)**

Y) Deliberation of Items Added After Preparation of the Agenda

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

Z) Consulting with Legal Counsel

RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION

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

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

ADJOURNMENT

**CONVENE TO DISCIPLINARY GUIDELINES COMMITTEE MEETING
IMMEDIATELY FOLLOWING FULL BOARD MEETING**

ATTENDEES: Kenneth Simons, Timothy Swan, Greg Collins

**ORAL EXAMINATION OF CANDIDATES FOR LICENSURE
ROOM 121A, B, C, AND 199B
IMMEDIATELY FOLLOWING FULL BOARD MEETING**

CLOSED SESSION – Reviewing applications and conducting oral examinations of seven (7) candidates for licensure – Drs. Capodice, Erickson, Vasudevan, and Yale

**MEDICAL EXAMINING BOARD
MEETING MINUTES
JANUARY 15, 2014**

PRESENT: Kenneth Simons, M.D.; Greg Collins; Timothy Westlake, M.D.; Timothy Swan, M.D.; Mary Jo Capodice, D.O.; Rodney Erickson, M.D.; Sridhar Vasudevan, M.D.; Carolyn Ogland, M.D.; Suresh Misra, M.D.; and Michael Phillips, M.D.

PRESENT VIA GOTO MEETING: Jude Genereaux

EXCUSED: Russell Yale, M.D.; James Barr, M.D.

STAFF: Tom Ryan, Executive Director; Pam Stach, Legal Counsel; Daniel Agne, Bureau Assistant; Joshua Archiquette, Executive Staff Assistant; and other Department staff

CALL TO ORDER

Kenneth Simons, Chair, called the meeting to order at 8:03 A.M. A quorum of eleven (11) members was confirmed.

ADOPTION OF AGENDA

Amendments:

- Item “L” (Open Session) **ADD** the agenda item titled “Supervising Physician : Physician Assistant Ratio – Requesting Variance”

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

APPROVAL OF MINUTES

MOTION: Sridhar Vasudevan moved, seconded by Mary Jo Capodice, to approve the minutes of December 11, 2013 as published. Motion carried unanimously.

ADMINISTRATIVE UPDATES

Jude Genereaux entered the meeting at 8:09 A.M.

ELECTION OF OFFICERS

BOARD CHAIR

NOMINATION: Suresh Misra nominated Kenneth Simons for the Office of Board Chair. Nomination carried by unanimous consent.

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

Kenneth Simons was elected as Board Chair.

VICE CHAIR

NOMINATION: Sridhar Vasudevan nominated Timothy Swan for the Office of Vice Chair. Nomination carried by unanimous consent.

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

Timothy Swan was elected as Vice Chair.

SECRETARY

NOMINATION: Greg Collins nominated Sridhar Vasudevan for the Office of Secretary. Nomination carried by unanimous consent.

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

Sridhar Vasudevan was elected as Secretary.

2014 ELECTION RESULTS	
Board Chair	Kenneth Simons
Vice Chair	Timothy Swan
Secretary	Sridhar Vasudevan

APPOINTMENT OF LIAISONS, ALTERNATES, AND DELEGATES

MONITORING LIAISON AND DELEGATED AUTHORITY MOTIONS

MOTION: Timothy Westlake moved, seconded by Timothy Swan, to appoint Sridhar Vasudevan as the Monitoring Liaison, and Mary Jo Capodice as the Alternate. Motion carried unanimously.

MOTION: Timothy Swan moved, seconded by Suresh Misra, to adopt the Roles and Authorities Delegated to the Monitoring Liaison and Department Monitor document as presented in today's agenda packet. Motion carried unanimously.

MOTION: Timothy Swan moved, seconded by Mary Jo Capodice, 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.

CREDENTIALING LIAISONS (TWO) AND ALTERNATES (TWO)

MOTION: Greg Collins moved, seconded by Sridhar Vasudevan, to appoint Mary Jo Capodice and Suresh Misra as the Credentialing Liaisons, and Timothy Westlake and Sridhar Vasudevan as the Alternates. Motion carried unanimously.

PROFESSIONAL ASSISTANCE PROCEDURE LIAISON AND ALTERNATE

MOTION: Timothy Westlake moved, seconded by Sridhar Vasudevan, to appoint Mary Jo Capodice as the Professional Assistance Procedure Liaison, and Michael Phillips as the Alternate. Motion carried unanimously.

LEGISLATIVE LIAISONS (FOUR)

MOTION: Suresh Misra moved, seconded by Greg Collins, to appoint Sridhar Vasudevan, Timothy Swan, Kenneth Simons, and Timothy Westlake as the Legislative Liaisons. Motion carried unanimously.

MAINTENANCE OF LICENSURE LIAISONS (TWO)

MOTION: Sridhar Vasudevan moved, seconded by Greg Collins, to appoint Rodney Erickson and Carolyn Ogland as the Maintenance of Licensure Liaisons, and Mary Jo Capodice as the Alternate. Motion carried unanimously.

OFFICE OF EDUCATION AND EXAMS LIAISON

MOTION: Sridhar Vasudevan moved, seconded by Greg Collins, to appoint Timothy Westlake as the Office of Education and Exams Liaison, and Timothy Swan as the Alternate. Motion carried unanimously.

CONTINUING EDUCATION LIAISON

MOTION: Sridhar Vasudevan moved, seconded by Timothy Swan, to appoint Rodney Erickson as the Continuing Education Liaison, and Michael Phillips as the Alternate. Motion carried unanimously.

WEBSITE LIAISON

MOTION: Timothy Westlake moved, seconded by Carolyn Ogland, to appoint Timothy Swan as the Website Liaison, and Greg Collins as the Alternate. Motion carried unanimously.

NEWSLETTER LIAISON

MOTION: Timothy Westlake moved, seconded by Suresh Misra, to appoint Kenneth Simons as the Newsletter Liaison, and Timothy Swan as the Alternate. Motion carried unanimously.

LEGISLATIVE/ADMINISTRATIVE RULE MATTERS

RULEMAKING ORDER CR 12-005 RELATING TO PHYSICIAN ASSISTANT PRACTICE

MOTION: Sridhar Vasudevan moved, seconded by Mary Jo Capodice, to approve the Adoption Order for Clearinghouse Rule CR 12-005. Motion carried unanimously.

2013 WISCONSIN ACT 111 AND MED 18 ALTERNATE MODES OF TREATMENT

MOTION: Timothy Swan moved, seconded by Sridhar Vasudevan, to request DSPS staff draft a Scope Statement revising MED 18, relating to Informed Consent. Motion carried unanimously.

165-MED 13.06 CONTINUING EDUCATION AUDIT SCOPE STATEMENT AND TIMELINE

MOTION: Timothy Swan moved, seconded by Sridhar Vasudevan, to authorize the Chair to approve the Scope Statement for implementation. Motion carried unanimously.

FEDERATION OF STATE MEDICAL BOARDS (FSMB) MATTERS

FSMB'S 102ND ANNUAL MEETING – APRIL 24-26, 2014 IN DENVER, COLORADO

MOTION: Sridhar Vasudevan moved, seconded by Michael Phillips, to designate Kenneth Simons as a Delegate, and Mary Jo Capodice as an Alternate, to attend the FSMB Annual Meeting on April 24 through 26, 2014 in Denver, Colorado, and to authorize travel. Motion carried unanimously.

MOTION: Sridhar Vasudevan moved, seconded by Suresh Misra, to designate Tom Ryan to attend the FSMB Annual Meeting on April 24 through 26, 2014 in Denver, Colorado, and to authorize travel. Motion carried unanimously.

LICENSING COMMITTEE REPORT

MOTION: Carolyn Ogland moved, seconded by Sridhar Vasudevan, to approve Timothy Swan or his designee to testify at any legislative proceeding involving the licensing bill. Motion carried unanimously.

MOTION: Sridhar Vasudevan moved, seconded by Mary Jo Capodice, to authorize the Licensing Committee to consider reentry into practice. Motion carried unanimously.

SCREENING PANEL REPORT

Jude Genereaux reported that fifty-three (53) cases were screened and nineteen (19) were opened.

VARIANCE REQUEST – SUPERVISING PHYSICIAN:PHYSICIAN ASSISTANT RATIO

MOTION: Timothy Swan moved, seconded by Sridhar Vasudevan, to approve the Request for Variance permitting Dr. Shekhar Dagam to supervise up to three (3) Physician Assistants, pursuant to Wisconsin Administrative Code MED 8.10 (1). Motion carried unanimously.

CONVENE TO CLOSED SESSION

MOTION: Timothy Swan moved, seconded by Greg Collins, to convene to Closed Session to deliberate on cases following Hearing § 19.85 (1) (a), Stats.; consider closing disciplinary investigations with Administrative Warning § 19.85 (1)(b), Stats., and 448.02(8), Stats. to consider individual histories or disciplinary data § 19.85(1) (f), Stats., and to confer with legal counsel § 19.85 (1) (g), Stats.). Kenneth Simons, Chair, read the language of the Motion. The vote of each member was ascertained by voice vote. Roll Call Vote: Greg Collins – yes; Timothy Westlake – yes; Timothy Swan – yes;; Mary Jo Capodice – yes; Rodney Erickson – yes; Sridhar Vasudevan – yes; Carolyn Ogland – yes; Suresh Misra – yes; Michael Phillips – yes; and Jude Genereaux – yes. Motion carried unanimously.

The Board convened to Closed Session at 9:40 A.M.

RECONVENE TO OPEN SESSION

MOTION: Greg Collins moved, seconded by Suresh Misra, to reconvene to Open Session. Motion carried unanimously.

The Board reconvened to Open Session at 1:03 P.M.

FULL BOARD ORAL EXAMINATION OF CANDIDATES FOR LICENSURE

MOTION: Suresh Misra moved, seconded by Timothy Westlake, to find that Ann M. Khanna, M.D., failed the Full Board Oral Examination. **Reason for Failure:** Lack of evidence of current competence. Motion carried unanimously.

MOTION: Sridhar Vasudevan moved, seconded by Suresh Misra, to deny the application of Ann M. Khanna, M.D., based upon the failure of the Full Board Oral Examination. Motion carried unanimously.

MOTION: Timothy Westlake moved, seconded by Greg Collins, to find that Omar N. Khatib, M.D., passed the Full Board Oral Examination. Motion carried.

Sridhar Vasudevan abstained from voting in the above matter.

MOTION: Timothy Westlake moved, seconded by Suresh Misra, to grant the application of Omar N. Khatib, M.D., for a license to practice medicine and surgery in the State of Wisconsin once all other requirements have been met. Motion carried unanimously.

Kenneth Simons recused himself and left the room for deliberation and voting in the matter of the Full Board Oral Examination of Omar N. Khatib, M.D.

MONITORING MATTERS

MOTION: Timothy Westlake moved, seconded by Suresh Misra, to deny the request of Roman Berezovski, M.D. **Reason for Denial:** Failure to comply with the terms of the Order. Motion carried unanimously.

Sridhar Vasudevan recused himself and left the room for deliberation and voting in the above matter.

DELIBERATION OF MOTION FOR REHEARING

MOTION: Timothy Swan moved, seconded by Sridhar Vasudevan, to deny the Petition for Rehearing in the Matter of Disciplinary Proceedings against Bashir A. Sheikh, M.D. – Case Number 10 MED 201 – Order Number 0002781. **Reason for Denial:** Failure to provide evidence of a material error of law or fact or discovery of new evidence sufficiently strong to reverse or modify the Order which could not have been previously discovered by due diligence. Motion carried unanimously.

MOTION: Timothy Swan moved, seconded by Suresh Misra, to refer the allegations regarding Grant Regional Health Center to the appropriate oversight authorities, and to refer the issue involving the Physician Assistant to the DSPS Screening Panel for the Medical Examining Board. Motion carried.

Sridhar Vasudevan abstained from voting in the above matter.

PRESENTATION AND DELIBERATION OF ORDERS FIXING COSTS

MOTION: Timothy Swan moved, seconded by Greg Collins, to reject the Petition Objecting to the Order Fixing Costs in the matter of disciplinary proceedings against Bashir A. Sheikh, M.D., Respondent – DLSC case number 10 MED 201. Motion carried unanimously.

MOTION: Timothy Swan moved, seconded by Greg Collins, to issue the Order Fixing Costs in the matter of disciplinary proceedings against Bashir A. Sheikh, M.D., Respondent – DLSC case number 10 MED 201. Motion carried unanimously.

MOTION: Suresh Misra moved, seconded by Timothy Westlake, to issue the Order Fixing Costs in the matter of disciplinary proceedings against Michael Mangold, M.D., Respondent – DLSC case number 12 MED 103 and case number 12 MED 235. Motion carried unanimously.

PRESENTATION AND DELIBERATION OF ADMINISTRATIVE WARNINGS

MOTION: Suresh Misra moved, seconded by Greg Collins, to issue an Administrative Warning and close case number 13 MED 396 (J.E.K.). Motion carried unanimously.

DELIBERATION OF COMPLAINTS FOR DETERMINATION OF PROBABLE CAUSE

MOTION: Timothy Swan moved, seconded by Mary Jo Capodice, to find probable cause to believe that Robert A. Cavanaugh, M.D., case number 12 MED 351, is guilty of unprofessional conduct and therefore issue the Complaint and hold a Hearing on such conduct pursuant to Wisconsin Statute 448.02 (3) (b). Motion carried.

Rodney Erickson recused himself and left the room for deliberation and voting in the above matter.

Sridhar Vasudevan voted no in the above matter.

MOTION: Mary Jo Capodice moved, seconded by Suresh Misra, to find probable cause to believe that Anne Krutchen Bartel, M.D., case number 12 MED 439, is guilty of unprofessional conduct and therefore issue the Complaint and hold a Hearing on such conduct pursuant to Wisconsin Statute 448.02 (3) (b). Motion carried unanimously.

Timothy Swan recused himself and left the room for deliberation and voting in the above matter.

PRESENTATION AND DELIBERATION ON PROPOSED STIPULATIONS, FINAL DECISIONS AND ORDERS

MOTION: Timothy Westlake moved, seconded by Suresh Misra, to adopt the Findings of Fact, Conclusions of Law, and Order in the matters of disciplinary proceedings against Michael D. Plooster, M.D., DLSC case number 11 MED 294; James P. Fogarty, M.D., DLSC case number 12 MED 217; and David L. Paustian, D.O., DLSC case number 12 MED 244. Motion carried unanimously.

MOTION: Greg Collins moved, seconded by Timothy Westlake, to adopt the Findings of Fact, Conclusions of Law, and Order in the matter of disciplinary proceedings against Moshe Schein, M.D., DLSC case number 13 MED 027. Motion carried unanimously.

Timothy Swan recused himself and left the room for deliberation and voting in the above matter.

APPLICATION MATTERS

MOTION: Timothy Westlake moved, seconded by Mary Jo Capodice, that, upon receipt and consideration of the requested additional information, the Board finds that the training and education of Oussama Darwish, M.D., is substantially equivalent to the requirements set forth in Wisconsin Statute 448.05 (2). Motion carried unanimously.

MOTION: Timothy Westlake moved, seconded by Mary Jo Capodice, to grant the application for licensure to Oussama Darwish, M.D., once all requirements are met. Motion carried unanimously.

CASE CLOSINGS

MOTION: Sridhar Vasudevan moved, seconded by Suresh Misra, to close DLSC case number 13 MED 073, against R.F.T., for IE (Insufficient Evidence); 13 MED 191, against R.F.T., for IE (Insufficient Evidence); 12 MED 452, against E.M.C., for NV (No Violation); 12 MED 384, against J.E.H., for NV (No Violation); 13 MED 249, against A.D.B., for NV (No Violation); 13 MED 307, against R.A.S., for NV (No Violation); and 13 MED 316, against M.J.R., for P2 (Prosecutorial Discretion). Motion carried unanimously.

Timothy Swan recused himself from voting in the matter of 12 MED 452 (E.M.C.).

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

MOTION: Suresh Misra moved, seconded by Timothy Westlake, to affirm all votes made in Closed Session. Motion carried unanimously.

ADJOURNMENT

MOTION: Suresh Misra moved, seconded by Sridhar Vasudevan, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 1:06 P.M.



SCOTT WALKER
OFFICE OF THE GOVERNOR
STATE OF WISCONSIN

P.O. Box 7863
MADISON, WI 53707

GOVERNOR'S APPOINTMENT

NAME: Dr. Mary Jo Capodice

MAILING ADDRESS: [REDACTED]

E-MAIL ADDRESS: [REDACTED]

RESIDES IN: [REDACTED]

TELEPHONE: [REDACTED]

OCCUPATION: [REDACTED]

APPOINTED TO: Medical Examining Board
Doctor-Osteopathy

TERM: A term to expire July 1, 2018

SUCCEEDS: Herself

SENATE CONFIRMATION: Required

DATE OF APPOINTMENT: July 1, 2014

DATE OF NOMINATION: January 6, 2014

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SCOTT WALKER
OFFICE OF THE GOVERNOR
STATE OF WISCONSIN

P.O. Box 7863
MADISON, WI 53707

GOVERNOR'S APPOINTMENT

NAME: Dr. Kenneth Simons

MAILING ADDRESS: [REDACTED]

E-MAIL ADDRESS: [REDACTED]

RESIDES IN: [REDACTED]

TELEPHONE: [REDACTED]

OCCUPATION: [REDACTED]

APPOINTED TO: Medical Examining Board
Doctor-Medicine 6

TERM: A term to expire July 1, 2018

SUCCEEDS: Himself

SENATE CONFIRMATION: Required

DATE OF APPOINTMENT: July 1, 2014

DATE OF NOMINATION: January 6, 2014

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Daniel Agne, Bureau Assistant on behalf of Tom Ryan, Executive Director		2) Date When Request Submitted: 2/7/14 Items will be considered late if submitted after 4:30 p.m. on the deadline date: <ul style="list-style-type: none"> ▪ 8 business days before the meeting for paperless boards ▪ 14 business days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: 2/19/14	5) Attachments: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6) How should the item be titled on the agenda page? Admin Updates - Delegated Authority Motion	
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: The MEB made 2 delegated authority motions at the 1/15 meeting, and still needs to make the following motion: MOTION: _____, 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 to act in urgent matters and to act when knowledge or experience in the profession is required to carry out the duties of the Board in accordance with the law.			
11) Authorization			
Daniel Agne <hr/> Signature of person making this request Date <hr/> Supervisor (if required) Date <hr/> 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.			

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2013 ASSEMBLY BILL 742

February 7, 2014 - Introduced by Representative SEVERSON, cosponsored by Senator VUKMIR. Referred to Committee on Health.

1 **AN ACT** *to repeal* 448.04 (1) (b) 2., 448.04 (1) (c), 448.065, 448.10 (1), (4) and (5),
2 448.10 (2m) and 448.10 (3m); *to renumber* 448.10 (1m); *to amend* 440.08 (2)
3 (a) (intro.), 448.02 (1), 448.02 (3) (a), 448.02 (3) (b), 448.02 (3) (c), 448.02 (3) (e),
4 448.02 (3) (h), 448.02 (4) (a), 448.02 (4) (b), 448.02 (5), 448.02 (6), 448.02 (8) (a),
5 448.02 (8) (b), 448.02 (8) (c), 448.05 (1) (c), 448.05 (1) (d), 448.05 (6) (a), 448.06
6 (title), 448.06 (1), 448.06 (1), 448.07 (1) (d), 448.08 (1) (a), 448.08 (1) (a) and
7 462.01 (4); *to repeal and recreate* 448.05 (2); and *to create* 448.04 (1) (ac),
8 448.04 (1) (bg) and (bm), 448.05 (2c), 448.05 (6) (at), 448.063 and 448.10 (1m),
9 (2m) and (3m) of the statutes; **relating to:** licensure of physicians; providing
10 an exemption from emergency rule procedures; and granting rule-making
11 authority.

Analysis by the Legislative Reference Bureau

Under current law, physicians are licensed under the authority of the Medical Examining Board (MEB), a credentialing board attached to the Department of Safety and Professional Services. A physician's credential to practice is known as a license to practice medicine and surgery. This bill makes various changes regarding

ASSEMBLY BILL 742

the licenses to practice medicine and surgery and related credentials issued by the MEB. Significant changes in the bill are described as follows:

REGULAR LICENSES TO PRACTICE MEDICINE AND SURGERY***Current law***

Current law provides that an applicant for any class of license to practice medicine and surgery must supply evidence satisfactory to the MEB that the applicant is a graduate of and possesses a diploma from a medical or osteopathic college approved by the MEB and has completed postgraduate training of 12 months in a facility approved by the MEB. Current law also contains provisions for issuing licenses to practice medicine and surgery to graduates of foreign medical schools that are not approved by the MEB. Such a graduate of a foreign medical school may be admitted to examination for a license to practice medicine and surgery if he or she satisfies certain requirements.

The bill — licensure of accredited medical and osteopathic college graduates

The bill repeals the provisions described above and replaces them with the following requirements that an applicant other than a graduate of a foreign medical college must satisfy in order to be eligible for a regular license to practice medicine and surgery:

1. That the applicant is a graduate of and possesses a diploma from a medical or osteopathic college that is accredited by the Liaison Committee on Medical Education, the American Osteopathic Association, or a successor organization and that is approved by the MEB.

2. That the applicant either: a) has successfully completed and received credit for 24 months of postgraduate training in one or more programs accredited by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or a successor organization; or b) be currently enrolled in a postgraduate training program accredited by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or a successor organization; has successfully completed and received credit for 12 consecutive months of postgraduate training in that program; and has received an unrestricted endorsement from the postgraduate training program director that includes confirmation that the applicant is expected to continue in the program and complete at least 24 months of postgraduate training.

3. That the applicant satisfies any other requirement established by the MEB by rule.

The bill — licensure of graduates of foreign medical colleges

The bill repeals the provisions described above and replaces them with the following requirements that an applicant who is a graduate of a foreign medical college must satisfy in order to be eligible for a regular license to practice medicine and surgery:

1. That the applicant be a graduate of and possess a diploma from a foreign medical college credentialed by an agency approved by the MEB.

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2. That the applicant has obtained certification by the Educational Council for Foreign Medical Graduates or a successor organization.

3. That the applicant has passed all steps of the United States Medical Licensing Examination administered by the National Board of Medical Examiners and the Federation of State Medical Boards, or their successor organizations.

4. That the applicant has successfully completed and received credit for 24 months of postgraduate training in one or more programs accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association or a successor organization, the last 12 months of which were completed in a single program.

5. That the applicant satisfies any other requirement established by the MEB by rule for issuing the license.

The bill — exceptions

The bill allows the MEB to promulgate rules specifying circumstances in which the MEB, in cases of hardship or in cases in which the applicant possesses a medical license issued by another jurisdiction, may grant a waiver from any requirement described above for a regular license to practice medicine and surgery. The MEB may grant such a waiver only in accordance with those rules.

The bill also grandfathers existing holders of a regular license to practice medicine and surgery so that they may retain and continue to renew their licenses notwithstanding the requirements in the bill described above.

CREDENTIALS FOR MEDICAL RESIDENTS***Current law — temporary educational permits***

Under current law, the MEB may grant a temporary educational permit to practice medicine and surgery (TEP) to a person who meets the requirements for a license to practice medicine and surgery, other than required examinations. A TEP may be issued for a period not to exceed one year and may be renewed annually for not more than four years. A TEP permits the holder to take postgraduate educational training in a facility approved by the MEB, and the holder of a TEP may, under the direction of a licensed physician, perform services requisite to that training, but must confine training and practice to the facility in which the holder is taking the training.

The bill — resident educational licenses

The bill repeals the provisions for granting a TEP and replaces them with provisions allowing the MEB to grant a resident educational license (REL). An applicant must, under the bill, satisfy the following requirements in order to be granted an REL:

1. Provide proof that he or she has been accepted into a postgraduate training program accredited by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or a successor organization.

2. Provide written confirmation from the institution sponsoring the postgraduate training program into which he or she has been accepted confirming the appointment to that program.

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3. Provide proof that he or she is a graduate of and possesses a diploma from a medical or osteopathic college that is approved by the MEB.

The bill provides that an REL is valid for one year and may be renewed for additional one-year terms while the REL holder is enrolled in his or her postgraduate training program. The bill also provides that an REL remains valid only while the REL holder is actively engaged in the practice of medicine and surgery in his or her postgraduate training program and is lawfully entitled to work in the United States. Finally, the bill provides that the holder of an REL may engage in the practice of medicine and surgery only in connection with his or her duties under his or her postgraduate training program.

The bill grandfathers existing TEP holders so that they may retain and renew their TEPs for up to three years following enactment of the bill.

LICENSES FOR VISITING PHYSICIANS***Current law — temporary licenses for visiting professors***

Under current law, an applicant who is a graduate of a foreign medical school and who, because of noteworthy professional attainment, is invited to serve on the academic staff of a medical college in this state as a visiting professor, may be granted a temporary license to practice medicine and surgery (visiting professor license). A visiting professor license remains in force only while the holder is serving full time on the academic staff of a medical college and the license holder's practice is limited to the duties of the academic position.

The bill — restricted licenses to practice as a visiting physician

The bill repeals the provisions for granting a visiting professor license and replaces them with provisions allowing the MEB to grant a restricted license to practice medicine and surgery as a visiting physician (visiting physician license). An applicant must, under the bill, satisfy the following requirements in order to be granted a visiting physician license:

1. Provide proof that he or she is a graduate of and possesses a diploma from a medical or osteopathic college that is approved by the board.

2. Provide proof that he or she teaches medicine, engages in medical research, or practices medicine and surgery outside this state.

3. Provide proof that the applicant is licensed to practice medicine and surgery outside this state.

4. Provide documentation that he or she intends to teach, research, or practice medicine and surgery at a medical education facility, medical research facility, or medical college in this state, which must include a signed letter from the dean or president of the facility or college.

5. Provide proof that he or she satisfies any other requirement established by the MEB by rule for issuing the license.

The bill provides that the holder of a visiting physician license may engage in the practice of medicine and surgery only at the medical education facility, medical research facility, or medical college where he or she is teaching, researching, or practicing, and only in accordance with the terms and restrictions established by the MEB. The bill provides that a visiting physician license is valid for one year and may be renewed at the discretion of the MEB. Finally, the bill provides that a visiting

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physician license remains valid only while the license holder is actively engaged in teaching, researching, or practicing medicine and surgery and is lawfully entitled to work in the United States.

The bill grandfathers existing visiting professor license holders so that they may retain and renew their visiting professor licenses for up to three years following enactment of the bill.

ADMINISTRATIVE PHYSICIAN LICENSE

The bill allows the MEB to grant a new type of license known under the bill as an administrative physician license (APL). The MEB may grant an APL to an applicant who satisfies the requirements for a regular license to practice medicine and surgery, other than any requirement established by the MEB relating to the active practice of medicine and surgery.

The bill provides that the holder of an APL may not, under that APL, take any action that constitutes the practice of medicine and surgery.

EXAMINATIONS FOR A LICENSE TO PRACTICE MEDICINE AND SURGERY

The bill provides that, when examining an applicant for a license to practice medicine and surgery or an APL, the MEB may only use examinations prepared, administered, and scored by national examining agencies, subject to the exception that the MEB may interview an individual applicant as needed to determine information specific to that applicant.

For further information see the *state* fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

1 **SECTION 1.** 440.08 (2) (a) (intro.) of the statutes is amended to read:

2 440.08 (2) (a) (intro.) Except as provided in par. (b) and in ss. 440.51, 442.04,
3 444.03, 444.11, 447.04 (2) (c) 2., ~~448.065~~, 449.17 (1m) (d), and 449.18 (2) (d) and
4 subch. II of ch. 448, the renewal dates for credentials are as follows:

5 **SECTION 2.** 448.02 (1) of the statutes is amended to read:

6 448.02 (1) LICENSE. The board may grant licenses, including various classes
7 of temporary licenses, to practice medicine and surgery, to practice as an
8 administrative physician, to practice perfusion, to practice as an anesthesiologist
9 assistant, and to practice as a physician assistant.

ASSEMBLY BILL 742**SECTION 3**

1 **SECTION 3.** 448.02 (3) (a) of the statutes is amended to read:

2 448.02 (3) (a) The board shall investigate allegations of unprofessional conduct
3 and negligence in treatment by persons holding a license, or certificate ~~or limited~~
4 ~~permit~~ granted by the board. An allegation that a physician has violated s. 253.10
5 (3), 448.30 or 450.13 (2) or has failed to mail or present a medical certification
6 required under s. 69.18 (2) within 21 days after the pronouncement of death of the
7 person who is the subject of the required certificate or that a physician has failed at
8 least 6 times within a 6-month period to mail or present a medical certificate
9 required under s. 69.18 (2) within 6 days after the pronouncement of death of the
10 person who is the subject of the required certificate is an allegation of unprofessional
11 conduct. Information contained in reports filed with the board under s. 49.45 (2) (a)
12 12r., 50.36 (3) (b), 609.17 or 632.715, or under 42 CFR 1001.2005, shall be
13 investigated by the board. Information contained in a report filed with the board
14 under s. 655.045 (1), as created by 1985 Wisconsin Act 29, which is not a finding of
15 negligence or in a report filed with the board under s. 50.36 (3) (c) may, within the
16 discretion of the board, be used as the basis of an investigation of a person named in
17 the report. The board may require a person holding a license, or certificate ~~or limited~~
18 ~~permit~~ to undergo and may consider the results of one or more physical, mental or
19 professional competency examinations if the board believes that the results of any
20 such examinations may be useful to the board in conducting its investigation.

21 **SECTION 4.** 448.02 (3) (b) of the statutes is amended to read:

22 448.02 (3) (b) After an investigation, if the board finds that there is probable
23 cause to believe that the person is guilty of unprofessional conduct or negligence in
24 treatment, the board shall hold a hearing on such conduct. The board may use any
25 information obtained by the board or the department under s. 655.17 (7) (b), as

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1 created by 1985 Wisconsin Act 29, in an investigation or a disciplinary proceeding,
2 including a public disciplinary proceeding, conducted under this subsection and the
3 board may require a person holding a license, or certificate ~~or limited permit~~ to
4 undergo and may consider the results of one or more physical, mental or professional
5 competency examinations if the board believes that the results of any such
6 examinations may be useful to the board in conducting its hearing. A unanimous
7 finding by a panel established under s. 655.02, 1983 stats., or a finding by a court that
8 a physician has acted negligently in treating a patient is conclusive evidence that the
9 physician is guilty of negligence in treatment. A finding that is not a unanimous
10 finding by a panel established under s. 655.02, 1983 stats., that a physician has acted
11 negligently in treating a patient is presumptive evidence that the physician is guilty
12 of negligence in treatment. A certified copy of the findings of fact, conclusions of law
13 and order of the panel or the order of a court is presumptive evidence that the finding
14 of negligence in treatment was made. The board shall render a decision within 90
15 days after the date on which the hearing is held or, if subsequent proceedings are
16 conducted under s. 227.46 (2), within 90 days after the date on which those
17 proceedings are completed.

18 **SECTION 5.** 448.02 (3) (c) of the statutes is amended to read:

19 448.02 (3) (c) Subject to par. (cm), after a disciplinary hearing, the board may,
20 when it determines that a panel established under s. 655.02, 1983 stats., has
21 unanimously found or a court has found that a person has been negligent in treating
22 a patient or when it finds a person guilty of unprofessional conduct or negligence in
23 treatment, do one or more of the following: warn or reprimand that person, or limit,
24 suspend or revoke any license, or certificate ~~or limited permit~~ granted by the board
25 to that person. The board may condition the removal of limitations on a license, or

ASSEMBLY BILL 742**SECTION 5**

1 certificate ~~or limited permit~~ or the restoration of a suspended or revoked license, or
2 certificate ~~or limited permit~~ upon obtaining minimum results specified by the board
3 on one or more physical, mental or professional competency examinations if the
4 board believes that obtaining the minimum results is related to correcting one or
5 more of the bases upon which the limitation, suspension or revocation was imposed.

6 **SECTION 6.** 448.02 (3) (e) of the statutes is amended to read:

7 448.02 (3) (e) A person whose license, or certificate ~~or limited permit~~ is limited
8 under this subchapter shall be permitted to continue practice upon condition that the
9 person will refrain from engaging in unprofessional conduct; that the person will
10 appear before the board or its officers or agents at such times and places as may be
11 designated by the board from time to time; that the person will fully disclose to the
12 board or its officers or agents the nature of the person's practice and conduct; that
13 the person will fully comply with the limits placed on his or her practice and conduct
14 by the board; that the person will obtain additional training, education or
15 supervision required by the board; and that the person will cooperate with the board.

16 **SECTION 7.** 448.02 (3) (h) of the statutes is amended to read:

17 448.02 (3) (h) Nothing in this subsection prohibits the board, in its discretion,
18 from investigating and conducting disciplinary proceedings on allegations of
19 unprofessional conduct by persons holding a license, or certificate ~~or limited permit~~
20 granted by the board when the allegations of unprofessional conduct may also
21 constitute allegations of negligence in treatment.

22 **SECTION 8.** 448.02 (4) (a) of the statutes is amended to read:

23 448.02 (4) (a) The board may summarily suspend any license, or certificate, ~~or~~
24 limited permit granted by the board when the board has in its possession evidence
25 establishing probable cause to believe that the holder of the license, or certificate, ~~or~~

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1 ~~limited permit~~ has violated the provisions of this subchapter and that it is necessary
2 to suspend the license, or certificate, ~~or limited permit~~ immediately to protect the
3 public health, safety, or welfare. The holder of the license, or certificate, ~~or limited~~
4 ~~permit~~ shall be granted an opportunity to be heard during the determination of
5 probable cause. The board chair and 2 board members designated by the chair or,
6 if the board chair is not available, the board vice-chair and 2 board members
7 designated by the vice-chair, shall exercise the authority granted by this paragraph
8 to suspend summarily a license, or certificate, ~~or limited permit~~ in the manner
9 provided under par. (b).

10 **SECTION 9.** 448.02 (4) (b) of the statutes is amended to read:

11 448.02 (4) (b) An order of summary suspension shall be served upon the holder
12 of the license, or certificate, ~~or limited permit~~ in the manner provided in s. 801.11 for
13 service of summons. The order of summary suspension shall be effective upon service
14 or upon actual notice of the summary suspension given to the holder of the license,
15 or certificate, ~~or limited permit~~ or to the attorney of the license, ~~permit, or limited~~
16 ~~permit~~ certificate holder, whichever is sooner. A notice of hearing commencing a
17 disciplinary proceeding shall be issued no more than 10 days following the issuance
18 of the order of summary suspension. The order of summary suspension remains in
19 effect until the effective date of a final decision and order in the disciplinary
20 proceeding against the holder or until the order of summary suspension is
21 discontinued by the board following a hearing to show cause. The holder of the
22 license, or certificate, ~~or limited permit~~ shall have the right to request a hearing to
23 show cause why the order of summary suspension should not be continued and the
24 order of summary suspension shall notify the holder of the license, or certificate, ~~or~~
25 ~~limited permit~~ of that right. If a hearing to show cause is requested by the holder

ASSEMBLY BILL 742**SECTION 9**

1 of the license, or certificate, ~~or limited permit~~, the hearing shall be scheduled on a
2 date within 20 days of receipt by the board of the request for the hearing to show
3 cause.

4 **SECTION 10.** 448.02 (5) of the statutes is amended to read:

5 448.02 (5) VOLUNTARY SURRENDER. The holder of any license, or certificate ~~or~~
6 ~~limited permit~~ granted by the board may voluntarily surrender the license, or
7 certificate ~~or limited permit~~ to the secretary of the board, but the secretary may
8 refuse to accept the surrender if the board has received allegations of unprofessional
9 conduct against the holder of the license, or certificate ~~or limited permit~~. The board
10 may negotiate stipulations in consideration for accepting the surrender of licenses.

11 **SECTION 11.** 448.02 (6) of the statutes is amended to read:

12 448.02 (6) RESTORATION OF LICENSE, OR CERTIFICATE ~~OR LIMITED PERMIT~~. The board
13 may restore any license, or certificate ~~or limited permit~~ which that has been
14 voluntarily surrendered or revoked under any of the provisions of this subchapter,
15 on such terms and conditions as it may deem appropriate.

16 **SECTION 12.** 448.02 (8) (a) of the statutes is amended to read:

17 448.02 (8) (a) After an investigation by the board under sub. (3) (a) or by the
18 department under s. 440.03 (3m) or (5), the board may issue a private and
19 confidential administrative warning to a holder of a license, or certificate ~~or limited~~
20 ~~permit~~ if the board determines that there is evidence of misconduct by him or her.
21 The board may issue an administrative warning under this paragraph only if the
22 board determines that no further action is warranted because the matter involves
23 a first occurrence of minor misconduct and the issuance of an administrative
24 warning adequately protects the public by putting the holder of the license, or
25 certificate ~~or limited permit~~ on notice that any subsequent misconduct may result

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1 in disciplinary action. The board shall review the determination if the holder of the
2 license, or certificate ~~or limited permit~~ makes a personal appearance before the
3 board. Following the review, the board may affirm, rescind or modify the
4 administrative warning. A holder of a license, or certificate ~~or limited permit~~ may
5 seek judicial review under ch. 227 of an affirmation or modification of an
6 administrative warning by the board.

7 **SECTION 13.** 448.02 (8) (b) of the statutes is amended to read:

8 448.02 (8) (b) An administrative warning issued under par. (a) does not
9 constitute an adjudication of guilt or the imposition of discipline and may not be used
10 as evidence that the holder of a license, or certificate ~~or limited permit~~ is guilty of
11 misconduct.

12 **SECTION 14.** 448.02 (8) (c) of the statutes is amended to read:

13 448.02 (8) (c) Notwithstanding par. (b), if the board receives a subsequent
14 allegation of misconduct about a holder of a license, or certificate ~~or limited permit~~
15 to whom the board issued an administrative warning under par. (a), the board may
16 reopen the matter that resulted in the issuance of the administrative warning or use
17 the administrative warning in any subsequent disciplinary hearing under sub. (3)
18 (b) as evidence that he or she had actual knowledge that the misconduct that was the
19 basis for the administrative warning was contrary to law.

20 **SECTION 15.** 448.04 (1) (ac) of the statutes is created to read:

21 448.04 (1) (ac) *Administrative physician license.* The board may grant an
22 administrative physician license to an applicant who satisfies the requirements
23 under s. 448.05 (2c). The board shall issue a license under this paragraph subject
24 to the same terms as a license issued under par. (a), except that, notwithstanding any
25 other provision of law that permits a physician to engage in any act that constitutes

ASSEMBLY BILL 742**SECTION 15**

1 the practice of medicine and surgery, the holder of a license issued under this
2 paragraph may not engage in the practice of medicine and surgery except as
3 otherwise authorized under s. 448.03 (2) and may not practice as provided in s.
4 448.035.

5 **SECTION 16.** 448.04 (1) (b) 2. of the statutes is repealed.

6 **SECTION 17.** 448.04 (1) (bg) and (bm) of the statutes are created to read:

7 448.04 (1) (bg) *Restricted license to practice medicine and surgery as a visiting*
8 *physician.* 1. The board may grant a restricted license to practice medicine and
9 surgery as a visiting physician to an applicant who satisfies the requirements under
10 s. 448.05 (2) (e).

11 2. The holder of a license issued under this paragraph may engage in the
12 practice of medicine and surgery only at the medical education facility, medical
13 research facility, or medical college where the license holder is teaching, researching,
14 or practicing, and only in accordance with the terms and restrictions established by
15 the board.

16 3. Subject to subd. 4., a license issued under this paragraph is valid for one year
17 and may be renewed at the discretion of the board.

18 4. A license issued under this paragraph remains valid only while the license
19 holder is actively engaged in teaching, researching, or practicing medicine and
20 surgery and is lawfully entitled to work in the United States.

21 (bm) *Resident educational license to practice medicine and surgery.* 1. The
22 board may grant a resident educational license to practice medicine and surgery to
23 an applicant who satisfies the requirements under s. 448.05 (2) (d).

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1 2. Subject to subd. 3., a license issued under this paragraph is valid for one year
2 and may be renewed for additional one-year terms while the license holder is
3 enrolled in the postgraduate training program under s. 448.05 (2) (d) 1.

4 3. A license issued under this paragraph remains valid only while the license
5 holder is actively engaged in the practice of medicine and surgery in the
6 postgraduate training program under s. 448.05 (2) (d) 1. and is lawfully entitled to
7 work in the United States.

8 4. The holder of a license issued under this paragraph may engage in the
9 practice of medicine and surgery only in connection with his or her duties under the
10 postgraduate training program under s. 448.05 (2) (d) 1.

11 **SECTION 18.** 448.04 (1) (c) of the statutes is repealed.

12 **SECTION 19.** 448.05 (1) (c) of the statutes is amended to read:

13 448.05 (1) (c) Achieve a passing grade in ~~the~~ any examinations required in this
14 section.

15 **SECTION 20.** 448.05 (1) (d) of the statutes is amended to read:

16 448.05 (1) (d) Be found qualified by three-fourths of the members of the board,
17 except that an applicant for a temporary license or certificate under s. 448.04 (1) (b)
18 1. and 3., (e), and (g), or (i) or a resident educational license under s. 448.04 (1) (bm)
19 must be found qualified by 2 members of the board.

20 **SECTION 21.** 448.05 (2) of the statutes is repealed and recreated to read:

21 448.05 (2) LICENSE TO PRACTICE MEDICINE AND SURGERY. (a) Except as provided
22 in pars. (b) to (e), an applicant for any class of license to practice medicine and surgery
23 must supply evidence satisfactory to the board of all of the following:

24 1. That the applicant is a graduate of and possesses a diploma from a medical
25 or osteopathic college that is accredited by the Liaison Committee on Medical

ASSEMBLY BILL 742**SECTION 21**

1 Education, the American Osteopathic Association, or a successor organization and
2 that is approved by the board.

3 2. That the applicant satisfies one of the following:

4 a. The applicant has successfully completed and received credit for 24 months
5 of postgraduate training in one or more programs accredited by the Accreditation
6 Council for Graduate Medical Education, the American Osteopathic Association, or
7 a successor organization.

8 b. The applicant is currently enrolled in a postgraduate training program
9 accredited by the Accreditation Council for Graduate Medical Education, the
10 American Osteopathic Association, or a successor organization; the applicant has
11 successfully completed and received credit for 12 consecutive months of
12 postgraduate training in that program; and the applicant has received an
13 unrestricted endorsement from the postgraduate training program director that
14 includes confirmation that the applicant is expected to continue in the program and
15 complete at least 24 months of postgraduate training.

16 3. That the applicant satisfies any other requirement established by the board
17 by rule for issuing the license.

18 (b) Except as provided in pars. (c) to (e), an applicant for a license to practice
19 medicine and surgery who is a graduate of a foreign medical college must supply
20 evidence satisfactory to the board of all of the following:

21 1. That the applicant is a graduate of and possesses a diploma from a foreign
22 medical college credentialed by an agency approved by the board.

23 2. That the applicant has obtained certification by the Educational Council for
24 Foreign Medical Graduates or a successor organization.

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1 3. That the applicant has passed all steps of the United States Medical
2 Licensing Examination administered by the National Board of Medical Examiners
3 and the Federation of State Medical Boards, or their successor organizations.

4 4. That the applicant has successfully completed and received credit for 24
5 months of postgraduate training in one or more programs accredited by the
6 Accreditation Council for Graduate Medical Education or the American Osteopathic
7 Association or a successor organization, the last 12 months of which were completed
8 in a single program.

9 5. That the applicant satisfies any other requirement established by the board
10 by rule for issuing the license.

11 (c) The board may promulgate rules specifying circumstances in which the
12 board, in cases of hardship or in cases in which the applicant possesses a medical
13 license issued by another jurisdiction, may grant a waiver from any requirement
14 under par. (a) or (b). The board may grant such a waiver only in accordance with
15 those rules.

16 (d) An applicant for a resident educational license under s. 448.04 (1) (bm) shall
17 provide the board with all of the following:

18 1. Proof that the applicant has been accepted into a postgraduate training
19 program accredited by the Accreditation Council for Graduate Medical Education,
20 the American Osteopathic Association, or a successor organization.

21 2. Written confirmation from the institution sponsoring the postgraduate
22 training program into which the applicant has been accepted confirming that the
23 applicant has been or will be appointed to a position in the program.

24 3. Proof that the applicant is a graduate of and possesses a diploma from a
25 medical or osteopathic college that is approved by the board.

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1 (e) An applicant for a restricted license to practice medicine and surgery as a
2 visiting physician under s. 448.04 (1) (bg) shall provide the board with all of the
3 following:

4 1. Proof that the applicant is a graduate of and possesses a diploma from a
5 medical or osteopathic college that is approved by the board.

6 2. Proof that the applicant is licensed to practice medicine and surgery outside
7 this state.

8 3. Proof that the applicant teaches medicine, engages in medical research, or
9 practices medicine and surgery outside this state.

10 4. Documentation that the applicant intends to teach, research, or practice
11 medicine and surgery at a medical education facility, medical research facility, or
12 medical college in this state, which must include a signed letter from the dean or
13 president of the facility or college.

14 5. Proof that the applicant satisfies any other requirement established by the
15 board by rule for issuing the license.

16 **SECTION 22.** 448.05 (2c) of the statutes is created to read:

17 448.05 (2c) ADMINISTRATIVE PHYSICIAN LICENSE. An applicant for an
18 administrative physician license must supply evidence satisfactory to the board that
19 he or she satisfies the requirements for a license to practice medicine and surgery
20 under sub. (2) (a) or (b), subject to any waiver granted under sub. (2) (c), other than
21 any requirement established by the board by rule relating to the active practice of
22 medicine and surgery.

23 **SECTION 23.** 448.05 (6) (a) of the statutes is amended to read:

24 448.05 (6) (a) Except as provided in pars. (am) ~~and~~, (ar), and (at), the board
25 shall examine each applicant it finds eligible under this section in such subject

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1 matters as the board deems applicable to the class of license or certificate which the
2 applicant seeks to have granted. Examinations may be both written and oral. In lieu
3 of its own examinations, in whole or in part, the board may make such use as it deems
4 appropriate of examinations prepared, administered, and scored by national
5 examining agencies, or by other licensing jurisdictions of the United States or
6 Canada. The board shall specify passing grades for any and all examinations
7 required.

8 **SECTION 24.** 448.05 (6) (at) of the statutes is created to read:

9 448.05 (6) (at) When examining an applicant for a license to practice medicine
10 and surgery or an administrative physician license under par. (a), the board may only
11 use examinations prepared, administered, and scored by national examining
12 agencies, except that the board may interview an individual applicant as needed to
13 determine information specific to that applicant.

14 **SECTION 25.** 448.06 (title) of the statutes is amended to read:

15 **448.06 (title) License, or certificate ~~or limited permit~~ granted, denied.**

16 **SECTION 26.** 448.06 (1) of the statutes is amended to read:

17 448.06 (1) GRANT OF LICENSE, CERTIFICATE, OR LIMITED PERMIT. If Subject to s.
18 448.05 (1) (d), if three-fourths of the members of the board find that an applicant who
19 has passed the required examinations is qualified, the board shall so notify the
20 applicant and shall grant the license, certificate, or limited permit.

21 **SECTION 27.** 448.06 (1) of the statutes, as affected by 2013 Wisconsin Act ...

22 (this act), is amended to read:

23 448.06 (1) GRANT OF LICENSE; OR CERTIFICATE, ~~OR LIMITED PERMIT~~. Subject to s.
24 448.05 (1) (d), if three-fourths of the members of the board find that an applicant who

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1 has passed the required examinations is qualified, the board shall so notify the
2 applicant and shall grant the license, or certificate, ~~or limited permit~~.

3 **SECTION 28.** 448.063 of the statutes is created to read:

4 **448.063 Notification requirements for certain licenses.** (1) If the holder
5 of a license granted under the authority of s. 448.05 (2) (a) 2. b. subsequently
6 discontinues his or her postgraduate training program at any time prior to the
7 completion of the program, the program director shall notify the board, providing full
8 details of the cause of the discontinuance and the holder's plans, if any, for completion
9 of the postgraduate training program. The board shall review the matter and may
10 take any appropriate action.

11 (2) If the holder of a license granted under s. 448.04 (1) (bg) ceases to teach,
12 research, or practice medicine and surgery at the medical education facility, medical
13 research facility, or medical college where he or she is visiting, the medical education
14 facility, medical research facility, or medical college shall notify the board. The board
15 shall review the matter and may take any appropriate action.

16 **SECTION 29.** 448.065 of the statutes is repealed.

17 **SECTION 30.** 448.07 (1) (d) of the statutes is amended to read:

18 448.07 (1) (d) No registration may be permitted by the secretary of the board
19 in the case of any physician or perfusionist who has failed to meet the requirements
20 of s. 448.13 or any person whose license, or certificate, ~~or limited permit~~ has been
21 suspended or revoked and the registration of any such person shall be deemed
22 automatically annulled upon receipt by the secretary of the board of a verified report
23 of such suspension or revocation, subject to the licensee's ~~or permittee's~~ person's right
24 of appeal. A person whose license, or certificate, ~~or limited permit~~ has been
25 suspended or revoked and subsequently restored shall be registered by the board

ASSEMBLY BILL 742

1 upon tendering a verified report of such restoration of the license, or certificate, ~~or~~
2 ~~limited permit~~, together with an application for registration and the registration fee.

3 **SECTION 31.** 448.08 (1) (a) of the statutes is amended to read:

4 448.08 (1) (a) "Hospital" means an institution providing 24-hour continuous
5 service to patients confined therein which is primarily engaged in providing facilities
6 for diagnostic and therapeutic services for the surgical and medical diagnosis,
7 treatment and care, of injured or sick persons, by or under the supervision of a
8 professional staff of physicians and surgeons, and which is not primarily a place of
9 rest for the aged, drug addicts or alcoholics, or a nursing home. Such hospitals may
10 charge patients directly for the services of their employee nurses, nonphysician
11 anesthetists, physical therapists and medical assistants other than physicians or
12 dentists, and may engage on a salary basis interns and residents who are
13 participating in an accredited training program under the supervision of the medical
14 staff, and persons with a resident educational license issued under s. 448.04 (1) (bm)
15 or a temporary educational certificate issued under s. 448.04 (1) (c), 2011 stats.

16 **SECTION 32.** 448.08 (1) (a) of the statutes, as affected by 2013 Wisconsin Act
17 (this act), is amended to read:

18 448.08 (1) (a) "Hospital" means an institution providing 24-hour continuous
19 service to patients confined therein which is primarily engaged in providing facilities
20 for diagnostic and therapeutic services for the surgical and medical diagnosis,
21 treatment and care, of injured or sick persons, by or under the supervision of a
22 professional staff of physicians and surgeons, and which is not primarily a place of
23 rest for the aged, drug addicts or alcoholics, or a nursing home. Such hospitals may
24 charge patients directly for the services of their employee nurses, nonphysician
25 anesthetists, physical therapists and medical assistants other than physicians or

ASSEMBLY BILL 742**SECTION 32**

1 dentists, and may engage on a salary basis interns and residents who are
2 participating in an accredited training program under the supervision of the medical
3 staff, and persons with a resident educational license issued under s. 448.04 (1) (bm)
4 ~~or a temporary educational certificate issued under s. 448.04 (1) (c), 2011 stats.~~

5 **SECTION 33.** 448.10 (1), (4) and (5) of the statutes are repealed.

6 **SECTION 34.** 448.10 (1m), (2m) and (3m) of the statutes are created to read:

7 448.10 **(1m)** Notwithstanding s. 448.05 (2), a person who, on the effective date
8 of this subsection [LRB inserts date], possessed a valid license to practice
9 medicine and surgery under s. 448.05 (2) or 448.065, 2011 stats., may retain, practice
10 under, and continue to renew that license, subject to any other provisions in this
11 subchapter or any rules promulgated by the board governing a license to practice
12 medicine and surgery.

13 **(2m)** A person who, on the effective date of this subsection [LRB inserts
14 date], possessed a valid temporary license to practice medicine and surgery under
15 s. 448.04 (1) (b) 2., 2011 stats., may retain, practice under, and continue to renew that
16 license in accordance with s. 448.04 (1) (b) 2., 2011 stats., subject to any other
17 provisions in this subchapter or any rules promulgated by the board governing that
18 license.

19 **(3m)** A person who, on the effective date of this subsection [LRB inserts
20 date], possessed a valid temporary educational permit to practice medicine and
21 surgery under s. 448.04 (1) (c), 2011 stats., may retain, practice under, and continue
22 to renew that permit in accordance with s. 448.04 (1) (c), 2011 stats., subject to any
23 other provisions in this subchapter or any rules promulgated by the board governing
24 that permit, or may apply for a resident educational license under s. 448.04 (1) (bm).

ASSEMBLY BILL 742

1 **SECTION 35.** 448.10 (1m) of the statutes, as created by 2013 Wisconsin Act ...
2 (this act), is renumbered 448.10.

3 **SECTION 36.** 448.10 (2m) of the statutes, as created by 2013 Wisconsin Act ...
4 (this act), is repealed.

5 **SECTION 37.** 448.10 (3m) of the statutes, as created by 2013 Wisconsin Act ...
6 (this act), is repealed.

7 **SECTION 38.** 462.01 (4) of the statutes is amended to read:

8 462.01 (4) "Physician" means a person licensed to practice medicine and
9 surgery under s. 448.04 (1) (a) ~~or~~, (b), or (b).

10 **SECTION 39. Nonstatutory provisions.**

11 (1) Using the procedure under section 227.24 of the statutes, the medical
12 examining board may promulgate rules under section 448.40 (1) of the statutes that
13 are necessary to implement the changes in this act and rules under section 448.05
14 (2) (c), as affected by this act, for the period before the effective date of any permanent
15 rules promulgated under section 448.40 (1) of the statutes, but not to exceed the
16 period authorized under section 227.24 (1) (c) of the statutes, subject to extension
17 under section 227.24 (2) of the statutes. Notwithstanding section 227.24 (1) (a), (2)
18 (b), and (3) of the statutes, the board is not required to provide evidence that
19 promulgating a rule under this subsection as an emergency rule is necessary for the
20 preservation of the public peace, health, safety, or welfare and is not required to
21 provide a finding of emergency for a rule promulgated under this subsection.

22 **SECTION 40. Initial applicability.**

23 (1) The treatment of section 448.05 (6) (a) and (at) of the statutes first applies
24 to an applicant who is admitted to examination for a license to practice medicine and

ASSEMBLY BILL 742**SECTION 40**

1 surgery by the medical examining board under section 448.05 (2) of the statutes, as
2 affected by this act, on the effective date of this subsection.

3 (2) The treatment of section 448.05 (2) of the statutes first applies to an
4 application for a license to practice medicine and surgery under section 448.05 (2) of
5 the statutes, as affected by this act, that is received by the medical examining board
6 on the effective date of this subsection.

7 **SECTION 41. Effective dates.** This act takes effect on the first day of the 12th
8 month beginning after publication, except as follows:

9 (1) The treatment of sections 448.02 (3) (a), (b), (c), (e), and (h), (4) (a) and (b),
10 (5), (6), and (8) (a), (b), and (c), 448.06 (title) and (1) (by SECTION 27), 448.07 (1) (d),
11 and 448.08 (1) (a) (by SECTION 32) of the statutes, the repeal of section 448.10 (2m)
12 and (3m) of the statutes, and the renumbering of section 448.10 (1m) of the statutes
13 take effect on the first day of the 36th month beginning after publication.

14 (END)

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Shawn Leatherwood		2) Date When Request Submitted: February 7, 2014 <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 ▪ 08 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: February 19, 2014	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? 165-Med 13.03 CE Audit proposed rule	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both		8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input checked="" type="checkbox"/> No	
9) Name of Case Advisor(s), if required: N/A			
10) Describe the issue and action that should be addressed: <p>The Board will consider and approve of the proposed rule concerning audits of licensee's compliance with continuing education requirements and for posting of EIA Comments and submission to the Clearinghouse.</p>			
11) Shawn Leatherwood		Authorization February 7, 2014	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			
Date			
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Board Services Bureau Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

STATE OF WISCONSIN
MEDICAL EXAMINING BOARD

IN THE MATTER OF RULEMAKING	:	PROPOSED ORDER OF THE
PROCEEDINGS BEFORE THE	:	MEDICAL EXAMINING BOARD
MEDICAL EXAMINING BOARD	:	ADOPTING RULES
	:	(CLEARINGHOUSE RULE)

PROPOSED ORDER

An order of the Medical Examining Board to amend Med 13.06 relating to continuing education audits.

Analysis prepared by the Department of Safety and Professional Services.

ANALYSIS

Statutes interpreted:

Section 448.13 (1m), Stats.

Statutory authority:

Sections 15.08 (5) (b), 227.11 (2) (a), 448.13, 448.40 (1), Stats.

Explanation of agency authority:

Pursuant to ss. 15.08 (5) (b) and 227.11 (2) (a), the Medical Examining Board (Board) is generally empowered by the legislature to promulgate rules that will provide guidance within the profession and rules that interpret the statutes it enforces or administers. Section 448.40 (1), Stats., expressly grants the Board authority to draft rules that carry out the purposes of subchapter II of ch. 448 Stats. The Board administers s. 448.13, Stats., which sets forth the Board's authority to conduct random audits of continuing education compliance. The proposed rule seeks to require the performance of random audits in accordance with s. 448.13 (1m), Stats. Therefore, Board is both generally and specifically empowered to promulgate the proposed rule.

Related statute or rule:

None.

Plain language analysis:

The Medical Examining Board reviewed its administrative rules and observed that there was no mechanism to require standardized audits of licensee's continuing education compliance. The Board sought to rectify the matter by requiring a random audit of

licensee's continuing education compliance every two years. Auditing licensee's compliance with the continuing education requirement every two years will act as a deterrent to non-compliance and ensure that licensees are maintaining their skills in keeping with highest standards within the profession.

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

None.

Comparison with rules in adjacent states:

Illinois: Licensees in Illinois have a 36 month renewal cycle in which they must complete 150 hours of continuing medical education. Applicants are required to certify on their renewal application that they have complied with the continuing education requirement. It is the responsibility of each renewal applicant to retain or otherwise produce additional evidence of compliance in case of a random audit. ILL. ADMIN. CODE tit. 68 §1285.110 d).

Iowa: Licensees are required to maintain documentation evidencing completion of continuing education for five years after the date of continuing education and training. Conducting an audit is not compulsory but if an audit is conducted the licensee must respond within 30 days of a request made by the board. IOWA ADMIN. CODE r. 653-11.4 (7).

Michigan: Licensees must complete 150 hours of continuing education in 3 years. Licensees certify at the time of renewal that they have completed the required continuing education and must retain evidence of his or her compliance for a period of 4 years from the date of application. MICH. ADMIN. CODE r. 388.2381.

Minnesota: Minnesota has a 3 year cycle in which to complete 75 hours of continuing education. Licensees provide a signed statement to the board indicating compliance. Licensees that fail to comply are subject to discipline. Minn. R. 5605.0100.

Summary of factual data and analytical methodologies:

The Board reviewed its current administrative rules and observed that the rules did not require a standardized audit of licensee's compliance with continuing education requirement. The proposed rule seeks to address this concern. No other factual data or analytical methodologies were used. The Board ensures the accuracy, integrity, objectivity and consistency of data were used in preparing the proposed rule and related analysis.

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

These proposed rules do not have an economic impact on small businesses, as defined in s. 227.114 (1), Stats. The Department's Regulatory Review Coordinator may be contacted by email at Tom.Engels@wisconsin.gov, or by calling (608) 266-8608.

Fiscal Estimate and Economic Impact Analysis:

The Fiscal Estimate and Economic Impact Analysis are attached.

Effect on small business:

These proposed rules do not have an economic impact on small businesses, as defined in s. 227.114 (1), Stats. The Department's Regulatory Review Coordinator may be contacted by email at Tom.Engels@wisconsin.gov, or by calling (608) 266-8608.

Agency contact person:

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

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

Comments may be submitted to Shawn Leatherwood, Administrative Rules Coordinator, Department of Safety and Professional Services, Division of Policy Development, 1400 East Washington Avenue, Room 151, P.O. Box 8366, Madison, WI 53708-8935, or by email to Shancethea.L Leatherwood@wisconsin.gov. Comments **must be received on or before** * to be included in the record of rule-making proceedings.

TEXT OF RULE

SECTION 1. MED 13.06 is amended to read:

Med 13.06 The board shall conduct a random audit of licensees on a biennial basis for compliance with continuing education requirements. The board may require any physician to submit his or her evidence of compliance with the continuing education requirements to the board during the biennium for which 30 hours of credit are required for registration to audit compliance.

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

(END OF TEXT OF RULE)

Dated _____

Agency _____

Chairperson
Medical Examining Board

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Shawn Leatherwood		2) Date When Request Submitted: January 31, 2014	
		Items will be considered late if submitted after 4:30 p.m. and less than: ▪ 10 work days before the meeting for Medical Board ▪ 08 work days before the meeting for all others	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: February 19, 2014	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? 2009 Wisconsin Act 382 and Med 5.04	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required: N/A	
10) Describe the issue and action that should be addressed: <p>The Board will review 2009 Wisconsin Act 382 and discuss its impact on Med 5.04.</p>			
11) Shawn Leatherwood Signature of person making this request		Authorization	January 31, 2014 Date
Supervisor (if required)			Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Board Services Bureau Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

State of Wisconsin



2009 Assembly Bill 877

Date of enactment: May 18, 2010
Date of publication*: June 1, 2010

2009 WISCONSIN ACT 382

AN ACT to renumber and amend 448.015 (4), 448.02 (4) and 448.13 (1); to amend 448.04 (1) (c), 448.13 (1m), 448.40 (1) and 448.40 (2) (e); and to create 448.015 (4) (c), 448.115 and 448.13 (1) (a) 2. of the statutes; relating to: duties of physicians and of the Medical Examining Board and requiring the exercise of rule-making authority.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 448.015 (4) of the statutes is renumbered 448.015 (4) (intro.) and amended to read:

448.015 (4) (intro.) "Unprofessional conduct" means those all of the following:

(a) Those acts or attempted acts of commission or omission defined as unprofessional conduct by the board under the authority delegated to the board by s. 15.08 (5) (b) and any.

(b) Any act by a physician or physician assistant in violation of ch. 450 or 961.

SECTION 2. 448.015 (4) (c) of the statutes is created to read:

448.015 (4) (c) Failure by a physician to report as required under s. 448.115.

SECTION 3. 448.02 (4) of the statutes is renumbered 448.02 (4) (a) and amended to read:

448.02 (4) (a) The board may summarily suspend any license, certificate, or limited permit granted by the board for a period not to exceed 30 days pending hearing, when the board has in its possession evidence establishing probable cause to believe that the holder of the license, certificate, or limited permit has violated the provisions of this subchapter and that it is necessary to suspend the license, certificate, or limited permit immediately to pro-

tect the public health, safety, or welfare. The holder of the license, certificate, or limited permit shall be granted an opportunity to be heard during the determination of probable cause. The board chair and 2 board members designated by the chair or, if the board chair is not available, the board vice-chair and 2 board members designated by the vice-chair, shall exercise the authority granted by this paragraph to suspend summarily a license, certificate, or limited permit in the manner provided under par. (b).

(b) An order of summary suspension shall be served upon the holder of the license, certificate, or limited permit in the manner provided in s. 801.11 for service of summons. The order of summary suspension shall be effective upon service or upon actual notice of the summary suspension given to the holder of the license, certificate, or limited permit or to the attorney of the license, permit, or limited permit holder, whichever is sooner. A notice of hearing commencing a disciplinary proceeding shall be issued no more than 10 days following the issuance of the order of summary suspension. The board may designate any of its officers to exercise the authority granted by this subsection to suspend summarily a license, certificate or limited permit, but such suspension shall be for a period of time not to exceed 72 hours. If a license, certificate or limited permit has been summarily suspended by the board or any of its officers, the board

* Section 991.11, WISCONSIN STATUTES 2007-08: Effective date of acts. "Every act and every portion of an act enacted by the legislature over the governor's partial veto which does not expressly prescribe the time when it takes effect shall take effect on the day after its date of publication as designated" by the secretary of state [the date of publication may not be more than 10 working days after the date of enactment].

~~may, while the hearing is in progress, extend the initial 30-day period of suspension for an additional 30 days. If the holder of the license, certificate or limited permit has caused a delay in the hearing process, the board may subsequently suspend the license, certificate or limited permit from the time the hearing is commenced until a final decision is issued or may delegate such authority to the hearing examiner. order of summary suspension remains in effect until the effective date of a final decision and order in the disciplinary proceeding against the holder or until the order of summary suspension is discontinued by the board following a hearing to show cause. The holder of the license, certificate, or limited permit shall have the right to request a hearing to show cause why the order of summary suspension should not be continued and the order of summary suspension shall notify the holder of the license, certificate, or limited permit of that right. If a hearing to show cause is requested by the holder of the license, certificate, or limited permit, the hearing shall be scheduled on a date within 20 days of receipt by the board of the request for the hearing to show cause.~~

SECTION 4. 448.04 (1) (c) of the statutes is amended to read:

448.04 (1) (c) *Temporary educational permit to practice medicine and surgery.* Application for a temporary educational permit to practice medicine and surgery may be made to the board by a person who meets the requirements of s. 448.05 (2). Such permit may be issued for a period not to exceed one year and may be renewed annually for not more than 4 years. Such permit shall entitle the holder to take postgraduate educational training in a facility approved by the board. The holder of such permit may, under the direction of a person licensed to practice medicine and surgery in this state, perform services requisite to the training authorized by this section. Acting under such direction, the holder of such permit shall also have the right to prescribe drugs ~~other than narcotics~~ and to sign any certificates, reports, or other papers for the use of public authorities which are required of or permitted to persons licensed to practice medicine and surgery. The holder of such permit shall confine training and practice to the facility in which the holder is taking the training. The purpose of this paragraph is solely to provide opportunities in this state for the postgraduate education of certain persons having training in medicine and surgery satisfactory to the board, without compliance with the licensure requirements of this subchapter. Nothing in this paragraph changes in any respect the requirements for licensure to practice medicine and surgery in this state. The violation of this paragraph by the holder of such permit shall constitute cause for the revocation of the permit. All holders of such permits shall be subject to such provisions of this subchapter as the board, by rule, determines are appropriate and to any penalties applicable to those with a temporary or regular license to practice

medicine and surgery. The board may require an applicant for licensure under this paragraph to appear before a member of the board for an interview and oral examination.

SECTION 5. 448.115 of the statutes is created to read:

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

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

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

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

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

(2) No physician who reports to the board under sub. (1) may be held civilly or criminally liable or be found guilty of unprofessional conduct for reporting in good faith.

SECTION 6. 448.13 (1) of the statutes is renumbered 448.13 (1) (a) (intro.) and amended to read:

448.13 (1) (a) (intro.) ~~Each~~ Except as provided in par. (b), each physician shall, in each 2nd year at the time of application for a certificate of registration under s. 448.07, submit proof of attendance at and completion of ~~continuing all of the following:~~

1. Continuing education programs or courses of study approved for at least 30 hours of credit by the board within the 2 calendar years preceding the calendar year for which the registration is effective.

(b) The board may waive this requirement any of the requirements under par. (a) if it finds that exceptional circumstances such as prolonged illness, disability or other similar circumstances have prevented a physician from meeting the requirement requirements.

SECTION 7. 448.13 (1) (a) 2. of the statutes is created to read:

448.13 (1) (a) 2. Professional development and maintenance of certification or performance improvement or continuing medical education programs or courses of study required by the board by rule under s. 448.40 (1) and completed within the 2 calendar years preceding the calendar year for which the registration is effective.

SECTION 8. 448.13 (1m) of the statutes is amended to read:

448.13 (1m) The board shall, on a random basis, verify the accuracy of proof submitted by physicians under sub. (1) (a) and may, at any time during the 2 calendar years specified in sub. (1) (a), require a physician to submit proof of any continuing education, professional development, and maintenance of certification or perfor-

mance improvement or continuing medical education programs or courses of study that he or she has attended and completed at that time during the 2 calendar years.

SECTION 9. 448.40 (1) of the statutes is amended to read:

448.40 (1) The board may promulgate rules to carry out the purposes of this subchapter, including rules requiring the completion of continuing education, professional development, and maintenance of certification or performance improvement or continuing medical education programs for renewal of a license to practice medicine and surgery.

SECTION 10. 448.40 (2) (e) of the statutes is amended to read:

448.40 (2) (e) Establishing the criteria for the substitution of uncompensated hours of professional assistance volunteered to the department of health services for some or all of the hours of continuing education credits required under s. 448.13 (1) (a) 1. for physicians specializing in psychiatry. The eligible substitution hours shall involve professional evaluation of community programs for the certification and recertification of community mental health programs, as defined in s. 51.01 (3n), by the department of health services.

Chapter Med 5

TEMPORARY EDUCATIONAL PERMIT TO PRACTICE MEDICINE AND SURGERY

Med 5.01	Authority and purpose.
Med 5.02	Applications, credentials, and eligibility.
Med 5.03	Fees.
Med 5.035	Examination.

Med 5.04	Practice limitations.
Med 5.05	Revocation.
Med 5.06	Expiration and renewal.

Note: Chapter Med 5 as it existed on October 31, 1976 was repealed and a new chapter Med 5 was created effective November 1, 1976.

Med 5.01 Authority and purpose. The rules in this chapter are adopted by the medical examining board pursuant to the authority delegated by ss. 15.08 (5), 227.11 and 448.40, Stats., and govern application for temporary educational permit to practice medicine and surgery under s. 448.04 (1) (c), Stats., (hereinafter "temporary educational permit"), and also govern practice thereunder.

History: Cr. Register, October, 1976, No. 250, eff. 11-1-76; correction made under s. 13.93 (2m) (b) 7., Stats., Register, May, 1989, No. 401.

Med 5.02 Applications, credentials, and eligibility. An applicant who has been appointed to a postgraduate training program in a facility in this state approved by the board under the provisions of s. Med 1.02 (3) may apply to the board for a temporary educational permit to practice medicine and surgery and shall submit to the board the following:

(1) A completed and verified application form supplied by the board for this purpose. These application forms are furnished by the board to the directors of training programs in approved facilities in this state and are available to the applicant from such directors.

(2) The documentary evidence and credentials required under s. Med 1.02 (2), (4) and (5).

History: Cr. Register, October, 1976, No. 250, eff. 11-1-76.

Med 5.03 Fees. The required fees must accompany the application, and all remittances must be made payable to the Wisconsin department of safety and professional services.

History: Cr. Register, October, 1976, No. 250, eff. 11-1-76; am. Register, February, 1997, No. 494, eff. 3-1-97; correction made under s. 13.92 (4) (b) 6., Stats., Register February 2012 No. 673.

Med 5.035 Examination. Applicants shall complete an open book examination on statutes and rules governing the practice of medicine and surgery in Wisconsin.

History: Cr. Register, February, 1997, No. 494, eff. 3-1-97.

Med 5.04 Practice limitations. The holder of a temporary educational permit to practice medicine and surgery may, under the direction of a person licensed to practice medicine and surgery in this state, perform services requisite to the training program in which that holder is serving. Acting under such direction, the holder of such temporary educational permit shall also have the right to prescribe drugs other than narcotics and to sign any certificates, reports or other papers for the use of public authorities which are required of or permitted to persons licensed to practice medicine and surgery. The holder of such temporary educational permit shall confine his or her training and entire practice to the facility in which the permit holder is taking the training and to the duties of such training.

History: Cr. Register, October, 1976, No. 250, eff. 11-1-76; correction made under s. 13.93 (2m) (b) 5., Stats., Register, May, 1989, No. 401.

Med 5.05 Revocation. Violation by the holder of a temporary educational permit to practice medicine and surgery of any of the provisions of this chapter or of any of the provisions of the Wisconsin Administrative Code or of ch. 448, Stats., which apply to persons licensed to practice medicine and surgery shall be cause for the revocation of such temporary educational permit.

History: Cr. Register, October, 1976, No. 250, eff. 11-1-76.

Med 5.06 Expiration and renewal. Temporary educational permits granted under this chapter shall expire one year from date of issuance and for cause shown to the satisfaction of the board may be renewed annually for not more than 4 such renewals, and the renewal fee shall be paid for each such renewal.

History: Cr. Register, October, 1976, No. 250, eff. 11-1-76.

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

AGENDA REQUEST FORM

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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 ▪ 08 work days before the meeting for all others 			
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: February 19, 2014	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Scope statement for Med 18.03 Informed Consent	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required: N/A	
10) Describe the issue and action that should be addressed: The Board will approve the scope statement on Med 18.03 relating to informed consent for submission to the Governor's office and publication and to authorize the Chair to approve the scope for implementation no less than 10 days after publication.			
11) Shawn Leatherwood	Authorization		January 31, 2014
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: <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 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. 			

STATEMENT OF SCOPE

MEDICAL EXAMINING BOARD

Rule No.: Med 18 and Med 5

Relating to: Informed Consent

Rule Type: Permanent

1. Finding/nature of emergency (Emergency Rule only):

N/A

2. Detailed description of the objective of the proposed rule:

The proposed rule will amend Wis. Admin. Code s. Med 18 to make it consistent with new legislation, 2013 Wisconsin Act 111.

3. Description of the existing policies relevant to the rule, new policies proposed to be included in the rule, and an analysis of policy alternatives:

2013 Wisconsin Act 111 impacts Wis. Admin. Code s. Med 18 by changing the manner in which Wisconsin physicians discuss alternate modes of treatment with their patients. Before the Act, physicians had a duty to inform their patients of all alternate, viable medical modes of treatment and about the benefits and risks of those treatments. Physicians were held to the reasonable patient standard, espoused by the Wisconsin Supreme Court, which provided physicians were to inform their patients of all information necessary for a reasonable person in the patient's position to make an intelligent decision with respect to the choices of treatment. Since the enactment of 2013 Wisconsin Act 111, physicians have a duty to inform their patients of all reasonable alternate medical modes of treatment and their risks and benefits instead of all alternate, viable medical modes of treatment. The legislation sets forth the reasonable physician standard, which requires disclosure only of information that a reasonable physician in the same or similar medical specialty would know and disclose under the circumstances. The proposed rule would amend Wis. Admin. Code s. Med 18 by incorporating the reasonable physician standard into the rule and making all such changes that would make the rule consistent with the statute.

The proposed rule would also seek to carry out the mandate of 2009 Wisconsin Act 382 by removing the terms "other than narcotics" from Wis. Admin. Code s. Med 5.04 which would allow temporary educational permit holders greater prescribing flexibility.

4. Detailed explanation of statutory authority for the rule (including the statutory citation and language):

Section 15.08 (5) (b), provides examining boards, such as the Medical Examining Board, "shall promulgate rules for its own guidance and for the guidance of the trade or profession to which it pertains, . . ." The proposed rule seeks to provide guidance within the profession on how physicians are to conduct their duty to inform patients of alternate modes of treatment.

Section 227.11 (2) (a), Stats., discusses the parameters of an agency's rule-making authority, stating an agency, "may promulgate rules interpreting the provisions of the statute, but a rule is not valid if it exceeds the bounds of correct interpretation. . ." This section allows an agency to promulgate administrative rules which interpret the statutes it enforces or administers as long as the proposed rule does not exceed proper interpretation of the statute. Section 227.01 (1), Stats., defines agency as a board. The Medical Examining Board falls within the definition of agency and is therefore allowed to apply s. 227.11 (2) (a) to statutes it administers.

Rev. 3/6/2012

The proposed rule seeks to interpret s. 448.30, Stats., which provides,

Any physician who treats a patient shall inform the patient about the availability of reasonable alternate medical modes of treatment and about the benefits and risks of these treatments. The reasonable physician standard is the standard for informing a patient under this section. The reasonable physician standard requires disclosure only of information that a reasonable physician in the same or a similar medical specialty would know and disclose under the circumstances. The physician's duty to inform the patient under this section does not require disclosure of:

- (2) Detailed technical information that in all probability a patient would not understand.
- (3) Risks apparent or known to the patient.
- (4) Extremely remote possibilities that might falsely or detrimentally alarm the patient.
- (5) Information in emergencies where failure to provide treatment would be more harmful to the patient than treatment.
- (6) Information in cases where the patient is incapable of consenting.
- (7) Information about alternate medical modes of treatment for any condition the physician has not included in his or her diagnosis at the time the physician informs the patient.

Section 448.40 (2) (a), Stats., sets forth the legislature's express grant of authority to the Medical Examining Board to promulgate rules implementing s. 448.30, Stats.

5. Estimate of amount of time that state employees will spend developing the rule and of other resources necessary to develop the rule:

State employees will spend approximately 50 hours developing this proposed rule.

6. List with description of all entities that may be affected by the proposed rule:

The proposed rule will affect licensed physicians, licensed physician assistants and their patients and those persons who hold temporary educational permits to practice medicine and surgery.

7. Summary and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:

None.

8. Anticipated economic impact of implementing the rule (note if the rule is likely to have a significant economic impact on small businesses):

The proposed rule is not likely to have significant economic impact on small businesses.

Contact Person: Shawn Leatherwood

Department Head or Authorized Signature

Date Submitted

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Joshua Archiquette, Executive Staff Assistant		2) Date When Request Submitted: 5 Dec 2013 <small>Items will be considered late if submitted after 4:30 p.m. and less than 8 work days before the meeting.</small>	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: 19 Feb 2014	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? FSMB Matters 1. Minimum Data Set Pilot Implementation Project	
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: The Board will discuss the Minimum Data Pilot Implementation Project			
11) Authorization			
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.			

From: [REDACTED]
To: [REDACTED]
Cc: [REDACTED]
Subject: FW: Minimum Data Set Pilot
Date: Thursday, November 07, 2013 8:12:45 AM
Attachments: [REDACTED]
Importance: High

Josh, please add to the MEB agenda, including the e-mail and the attachments. Thanks!



November 4, 2013

Dear Executive Director:

I am pleased to take this opportunity to update you on the progress that has been made in advancing the physician **Minimum Data Set (MDS)** initiative and to offer an opportunity to your state board to participate in an MDS Pilot Implementation Project this year.

Understanding the physician workforce is vital considering the gradual but undeniable shift in the demographic composition of the United States, and the expected impact of health care reform. The country's population makeup is aging, and the Affordable Care Act is expected to provide health care coverage to as many 30 million Americans by 2019. Not only is the demand for healthcare increasing, but concerns about the sustainability, cost, and delivery of health care underscore the importance of understanding the physician workforce.

Through the license renewal process, state medical and osteopathic boards are in a unique position to collect additional, up-to-date workforce information from physicians. Implementing a simple MDS using a uniform, basic set of questions which provide data describing where physicians are practicing, who is providing patient care and the types of care they are providing will offer greater insight to state and federal policymakers as coordinated efforts are made to deliver quality health care that is affordable, efficient and accessible.

The input that many of you have provided, directly or indirectly, to the discussions we have had culminated in the adoption by our House of Delegates of a Recommended Framework for a Minimum Physician Data Set. Input that Executive Directors have provided more recently indicates strong support for collecting workforce data. Earlier this year, 55 individuals from 69 of the state boards completed a survey about workforce and an MDS. The survey revealed that 82% of the responding boards said collecting workforce data is "extremely important" or "important" and many state boards are already collecting some of the data for an MDS.

This past month the FSMB was awarded a supplemental grant, through the Licensure Portability Program, to be used specially for a pilot project to begin implementation of a state-based MDS in the United States. The FSMB stands ready to assist, and is excited about working with state boards on this important initiative. The ultimate decision about whether and how MDS will get implemented, of course, remains with each of the state medical and osteopathic boards.

Please let us know by November 15, 2013 if your state medical or osteopathic board may be interested in participating with the FSMB in an MDS Pilot Implementation Project beginning this year. Once we have ascertained which of the state boards are ready to move forward we will reach out with our staff to explore each board's specific needs, capabilities, resources,

interests, goals and concerns.

I look forward to hearing from you shortly.

Sincerely,

Humayun J. Chaudhry, D.O., MACP, FACOI
President and Chief Executive Officer

Federation of State Medical Boards
400 Fuller Wiser Road | Suite 300 | Euless, TX 76039

www.fsmb.org



Physician Minimum Data Set Questions

1. What is your current employment status?
 - Actively working in a position that requires a medical license
 - Actively working in a field other than medicine
 - Not currently working
 - Retired

2. Are you currently providing direct clinical or patient care on a regular basis?
 - Yes
 - No
 - a. If no, how many years has it been since you provided clinical or patient care?
 - Less than 2 years
 - 2 to 5 years
 - 5 to 10 years
 - More than 10 years

3. Which of the following categories best describes your primary and secondary practice or work setting(s) where you work the most hours each week?

Practice Setting	Principal	Secondary
Office/Clinic—Solo Practice	0	0
Office/Clinic—Partnership	0	0
Office/Clinic—Single Specialty Group	0	0
Office/Clinic—Multi Specialty Group	0	0
Hospital—Inpatient	0	0
Hospital—Outpatient	0	0
Hospital—Emergency Department	0	0
Hospital—Ambulatory Care Center	0	0
Federal Government Hospital	0	0
Research Laboratory	0	0
Medical School	0	0
Nursing Home or Extended Care Facility	0	0
Home Health Setting	0	0
Hospice Care	0	0
Federal/State/Community Health Center(s)	0	0
Local Health Department	0	0
Telemedicine	0	0
Volunteer in a Free Clinic	0	0
Other (specify):	0	0

4. Which of the following best describes the area(s) of practice in which you spend most of your professional time:

Area of Practice	Principal	Secondary	Completed Accredited Residency Program or Fellowship
Adolescent Medicine	0	0	0
Anesthesiology	0	0	0
Allergy and Immunology	0	0	0
Cardiology	0	0	0
Child Psychiatry	0	0	0
Colon and Rectal Surgery	0	0	0
Critical Care Medicine	0	0	0
Dermatology	0	0	0
Endocrinology	0	0	0
Emergency Medicine	0	0	0
Family Medicine/General Practice	0	0	0
Gastroenterology	0	0	0
Geriatric Medicine	0	0	0
Gynecology Only	0	0	0
Hematology & Oncology	0	0	0
Infectious Diseases	0	0	0
Internal Medicine (General)	0	0	0
Nephrology	0	0	0
Neurological Surgery	0	0	0
Neurology	0	0	0
Obstetrics and Gynecology	0	0	0
Occupational Medicine	0	0	0
Ophthalmology	0	0	0
Orthopedic Surgery	0	0	0
Other Surgical Specialties	0	0	0
Otolaryngology	0	0	0
Pathology	0	0	0
Pediatrics (General)	0	0	0
Pediatrics Subspecialties	0	0	0
Physical Med. & Rehab.	0	0	0
Plastic Surgery	0	0	0
Preventive Medicine/Public Health	0	0	0
Psychiatry	0	0	0
Pulmonology	0	0	0
Radiation Oncology	0	0	0
Radiology	0	0	0
Rheumatology	0	0	0
Surgery (General)	0	0	0
Thoracic Surgery	0	0	0
Urology	0	0	0
Vascular Surgery	0	0	0
Other Specialties	0	0	0

5. How many weeks did you work in medical related positions in the past 12 months?
6. For all medical related positions held in (insert state name), indicate the average number of hours per week spent on each major activity:

Clinical or patient care	_____ hours/week
Research	_____ hours/week
Teaching/Education	_____ hours/week
Administration	_____ hours/week
Volunteering (medical related only)	_____ hours/week
Other (specify): _____	_____ hours/week

Another approach to obtaining this information would be to ask licensees: (1) number of weeks worked in the past 12 months, (2) average number of hours worked per week, and (3) the percentage of time per week spent on each major activity (e.g., clinical or patient care, research etc.).

7. What is the location of the site(s) where you spend most of your time providing direct clinical or patient care? Please enter the complete address for up to three locations and your direct patient care hours per week at each site.

Principal Location Address

Number	Street
City/Town	State
Zip Code: □□□□□	
Direct patient care hours per week at site: _____	

Second Location Address

Number	Street
City/Town	State
Zip Code: □□□□□	
Direct patient care hours per week at site: _____	

Third Location Address

Number	Street
City/Town	State
Zip Code: □□□□□	
Direct patient care hours per week at site: _____	

8. What is your sex?
 - Male
 - Female

Optional Questions

9. What is your race? (1 or more categories may be selected)—**Optional**
- White
 - Black or African American
 - American Indian or Alaska Native
 - Asian
 - Native Hawaiian/Other Pacific Islander
 - Other (specify)

The workgroup acknowledges that this is a condensed list and state boards may choose to use more detailed response sets (e.g., HHS Data Standards for Race and US Census Bureau Race Categories).

10. Ethnicity: Are you Hispanic, Latino/a, or of Spanish origin?
(1 or more categories may be selected)—**Optional**
- No
 - Yes, Mexican, Mexican American, Chicano/a
 - Yes, Puerto Rican
 - Yes, Cuban
 - Yes, Another Hispanic, Latino/a, or of Spanish origin (specify)

11. Do you speak a language other than English at home? **Optional**
- a. Yes
 - b. No

12. What is this language? (if you answered Yes to #11) **Optional**
- a. Spanish
 - b. Other Language (identify)

Workgroup to Define a Minimal Data Set

Report on a Recommended Framework for a Minimal
Physician Data Set

April 2012

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PARTICIPANTS ON THE WORKGROUP TO DEFINE A MINIMAL DATA SET

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Board of Directors, Federation of State Medical Boards
Executive Director, State Medical Board of Ohio

Mark A. Eggen, MD
Minnesota Board of Medical Practice

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Sheila R. Still
Admin Asst, Education and Library
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**FEDERATION OF STATE MEDICAL BOARDS
WORKGROUP TO DEFINE A MINIMAL DATA SET**

Report to the Federation of State Medical Boards of the United States, Inc.

INTRODUCTION AND CHARGE

The passage of the Patient Protection and Affordable Care Act (ACA) in 2010, the aging of the population and the overall growth of the population have been described as three of the most important factors influencing why accurate assessments of the supply and demand for physicians are critical to understanding the health care needs of residents throughout the United States and its territories. Under the ACA, it is estimated that by 2019 an additional 32 million Americans may become insured.ⁱ In terms of demographics, the total population of the United States is projected to grow by 60 million, to a total of 373 million, by 2030.ⁱⁱ Additionally, baby boomers started turning 65 in 2011 and each day for the next 19 years an estimated 10,000 boomers will reach age 65.ⁱⁱⁱ By 2030, all boomers will be 65 years of age or older and represent nearly 20% of the total population.^{iv} Health-care reform, a growing and aging population combined with a projected physician shortage as high as 130,000 by 2025,^v underscore the importance of knowing as much as possible about the physician workforce. How this challenge is addressed will impact many areas of the physician education and qualification process, including initial medical licensure (e.g., number of test administrations) and Maintenance of Licensure (MOL), specialty certification and Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC).

As part of their ongoing effort to protect the public, the nation's state medical boards regularly collect and disseminate information about actively licensed physicians in their jurisdictions to the Federation of State Medical Boards (FSMB) Physician Data Center. In 2010, the FSMB systematically collated and analyzed all of this data to determine an accurate count of the number, age, specialty certification, and location by region of actively licensed physicians in the United States and the District of Columbia.^{vi} The inaugural 2010 FSMB Census was successful and highlighted the need for additional research. A limitation of the 2010 FSMB Census data was that it did not contain information about a physician's professional activity. Physicians engage in patient care and/or other non-patient care activities, including teaching, administration, research or other professional activities. Although non-patient care includes important activities that contribute to quality health care delivery, many physicians involved in such activities may have an active license, which may contribute to an overestimation of the current physician workforce of physicians able to directly deliver health care. Furthermore, a licensed physician may be retired or work only part time, which could also contribute to an overestimation of the current physician workforce.

It was clear from the census that opportunities exist for future analyses that could be maximized with an expanded data-collection collaboration between the FSMB, its member boards, and other organizations within the house of medicine. In 2011, the FSMB House of Delegates adopted a

resolution that called for the FSMB, in cooperation with state medical boards, to develop a minimum physician demographic and practice data set, as well as a data collection tool and physician data repository. The FSMB Board of Directors, led by Board Chair Janelle Rhyne, MD, MA, MACP, created the FSMB Workgroup to Define a Minimal Data Set.

The FSMB's Minimal Data Set (MDS) Workgroup convened in the summer of 2011 and was charged with consulting with national workforce groups such as the National Center for Health Workforce Analysis (NCHWA) to facilitate development of a minimal physician demographic data set as well as to develop a minimum physician demographic data collection tool and a physician demographic data repository. In carrying out its charge, the MDS Workgroup was asked to build and recommend a framework for state boards, or their designated affiliate organizations, to collect and share with the FSMB additional demographic and practice data for physicians licensed in their jurisdictions.

IMPORTANCE OF A MINIMAL PHYSICIAN DATA SET

The MDS Workgroup identified five key reasons why establishing a minimal data set is important to the health care system:

1. Physician workforce participation (entry, retention, exit and reentry) is subject to unpredictable economic factors, licensure and certification requirements, skills portability, as well as structural workforce issues such as participation levels, workforce aging, lifestyle factors, and gender.
2. Because physicians renew their license on a regular basis, working with state medical boards on a minimal data set is a cost-effective approach for collecting basic physician data.
3. It provides accurate and consistent information about physicians to state and federal policy makers which could be used in planning and resource allocation. Accurate projections of physician supply inform policymakers about the number and specialty composition of physicians, as well as help determine the need for other health care practitioners.
4. Some individuals hold licenses in more than one jurisdiction; uniform physician workforce data would lead to a better understanding of geographic participation and migratory patterns.
5. Physician supply and composition impact areas of the education and qualification process, including initial licensure, Maintenance of Licensure (MOL), specialty certification and Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC).

METHODOLOGY

The MDS Workgroup held teleconference meetings on July 12, 2011, and September 19, 2011. The workgroup also had one face-to-face meeting with representatives from the National Center for Health Workforce Analysis (NCHWA) in Washington, D.C., on November 22, 2011.

The MDS Workgroup agreed that a recommended framework for a minimal physician data set should be ready to be presented to the FSMB House of Delegates for a vote during the April 2012 FSMB Annual Meeting. However, if additional time was needed, an extension would be granted.

The MDS Workgroup used a knowledge-based approach to its deliberations. The workgroup reviewed pertinent health workforce literature, considered research conducted by other organizations, and studied standardized questions suggested by the NCHWA. To compare the current process being used and the physician workforce data elements being collected, the MDS Workgroup also gathered information available from 59 of the 69 FSMB member boards involved in licensing decisions. The information collected showed that 63 percent of responding boards collect at least some physician workforce data. As demonstrated by the findings, the procedures for collecting the data and the types of data elements collected vary noticeably for the 37 boards that indicated they collect information. Of the 37 boards that collect at least some physician workforce data the research indicates:

- 68 percent include workforce questions in their license renewal application
- 54 percent ask workforce questions that are voluntary
- 19 percent ask workforce questions that are mandatory
- 16 percent have a combination of voluntary and mandatory questions

In terms of demographic data sought by the boards, highlights from the 37 boards that collect data show similar variability:

- 49 percent ask for gender
- 46 percent ask for race
- 38 percent ask for ethnic background

The information collected also provided a range of other data points regarding physician characteristics and patient care. Generally, the research showed a fairly wide range of practices in terms of what kinds of questions are asked and what kind of information is being compiled by the boards.

Among the categories are questions about full-time vs. part-time practice, average hours per week per specialty area, hours per week spent in various practice settings, practice location and a variety of others.

- 78 percent ask if the physician works full time or part time
- 65 percent ask for practicing specialty(s)
- 49 percent ask average hours per week per specialty(s)
- 62 percent ask for average hours per week per practice setting

FRAMEWORK FOR A MINIMAL PHYSICIAN DATA SET

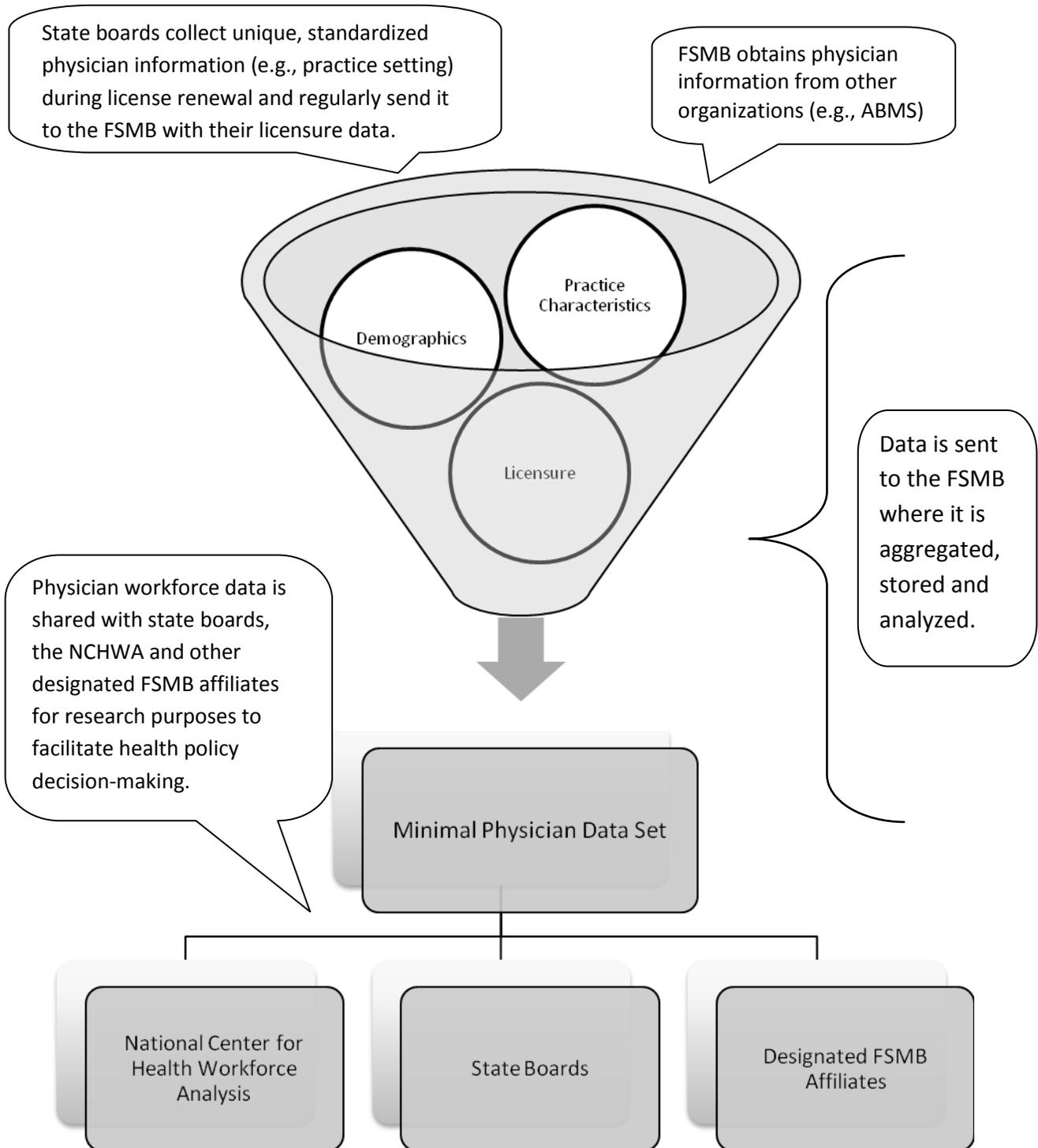
After reviewing applicable health workforce literature and analyzing information from state boards and the National Center for Health Workforce Analysis (NCHWA), the MDS Workgroup agreed that **a state board's license renewal process is a unique opportunity for collecting additional, up-to-date workforce information from physicians.** Twenty-six percent of state boards require physicians to renew their license every year, 66 percent require renewal once every two years and the remaining boards require renewal every three years or more. In addition, information gathered on the 37 boards that collect at least some physician workforce data indicated that the procedures for collecting data and the types of data elements collected vary considerably.

Based on this information, the MDS Workgroup developed and recommended a framework for a uniform minimal physician data set to be presented to the FSMB Board of Directors, state boards, and finally the FSMB House of Delegates at the 2012 FSMB Annual Meeting with the intent of future implementation by state medical and osteopathic boards. **The recommended principles of the framework for a minimal physician data set are:**

- **Workforce questions for a minimal physician data set should be added to a renewal application or be a separate questionnaire tied directly to the renewal process.** The collection process should be determined by each board, but the workgroup strongly recommends that the questions be a mandatory component to the renewal process to stress the importance of the data and maximize the quantity and quality of data collected. If a state board does not have authority to collect the majority of data suggested as part of license renewal, the board should consult with the FSMB and other state boards about establishing a survey to obtain workforce information from their licensees.
- **Workforce questions for a minimal physician data set should be standardized across all state boards and not found in other sources.** Questions should be straightforward for licensees, take about 10 minutes or less to answer, and be in an easy-to-use electronic format that follows best practices for user-friendly, survey interface design (e.g., drop-down menus).

- State boards may choose to collect data using various methods. To further enhance the value of their data, state boards may also choose to expand their data by adding other questions not recommended for the minimal physician data set. **State boards should share their methods for collecting physician data and the additional information they collect with the FSMB and other state boards to help establish best practices for collecting physician workforce data.**
- **The minimal physician data set is a shared responsibility, and the FSMB will assist state boards in building the database.**
- **Data for the minimal physician data set should be aggregated and stored in the FSMB's Federation Physician Data Center (FPDC).** The FPDC is a comprehensive central repository of state-based data that contains some biographical, educational and disciplinary information about physicians licensed in jurisdictions throughout the United States and its territories. The complete database contains more than 1.6 million physician records, including information about physicians who are currently licensed, no longer licensed, or deceased. The FPDC is continuously updated and the majority of state boards provide medical licensure information to the FPDC on a monthly or quarterly basis. The workgroup strongly recommends that the boards include physician data from standardized workforce questions with their regular transmissions of licensure data to the FPDC.
- **The FSMB should maintain a central repository of physician workforce data and create a confidential database for use by state boards, the NCHWA and other designated FSMB affiliates for research purposes.**
- **The FSMB should continue to collaborate with state boards and affiliate health care organizations to improve the collection and accuracy of physician workforce data.**

GRAPHIC REPRESENTATION OF A MINIMAL PHYSICIAN DATA SET



RECOMMENDED DATA ELEMENTS FOR A MINIMAL PHYSICIAN DATA SET

The MDS Workgroup identified the data elements listed below to be included in a uniform, minimal physician data set. The workgroup believes that many of the elements identified fall into one of three categories: (1) data currently provided by state boards as part of their regular transmissions of licensure data; (2) data that is or may be obtained by the FSMB through data sharing agreements with other organizations; or (3) unique and standardized data that state boards can obtain by adding questions to their renewal application or by asking questions as part of a separate questionnaire tied directly to the renewal process.

Data Element	Source and Rationale (when applicable)
Licensure status (active or inactive)	Currently provided by state boards.
Date of birth (mm/dd/yy)	Currently provided by state boards. FSMB has the date of birth for more than 96% of physicians with an active license.
Medical school graduated	Currently provided by state boards. FSMB has medical school matriculation data for more than 99% of physicians with an active license.
Medical school graduation year	Currently provided by state boards. FSMB has the medical school graduation year for more than 98% of physicians with an active license.
Specialty and subspecialty board certification	Obtained by FSMB. Specialty and subspecialty certification data is currently provided to FSMB by ABMS on a daily basis. FSMB is working with AOA to obtain access to their specialty and subspecialty certification data.
Maintenance of Certification and Osteopathic Continuous Certification	Obtained by FSMB from the ABMS and the AOA as the information becomes available.
Maintenance of Licensure	Provided by state boards as MOL programs are adopted and implemented.
Employment status	State board question. Physicians may hold an active license but be retired.
Provide clinical or patient care.	State board question. Physician may hold a position in a field of medicine, but do not provide direct patient care (important for reentry decisions by state boards).
If <u>no</u> , number of years since provided clinical or patient care	State board question. Provides important input for physician re-entry.
Areas of practice	State board question. This question provides input on the true areas of practice for a physician (primary care, dermatology, surgery).
Practice settings	State board question. Physician can practice in different settings (e.g., clinic or hospital).
Number of weeks worked during the past year	State board question. This information will help state boards better understand the level of participation among licensed physicians in their jurisdictions.
Average number of hours worked per week by activity	State board question. Some physicians are involved in direct patient care and work as an administrator and conduct research during the same week.
Clinical locations	State board question. Some physicians may work in more than one location.
Hours per week providing patient care by location	State board question. Some physicians may work varying amounts in more than one location.
Gender	State board question. FSMB to supplement with AAMC, AACOM, and ECFMG data.
Race (optional)	State board question. FSMB to supplement with AAMC, AACOM, and ECFMG data.
Ethnicity (optional)	State board question. FSMB to supplement with AAMC, AACOM, and ECFMG data.
Languages spoken (optional)	State board question.

RECOMMENDED QUESTIONS FOR A MINIMAL PHYSICIAN DATA SET

The MDS Workgroup strongly recommends that the physician workforce questions presented in this section be added to state boards' renewal applications or be a separate questionnaire tied directly to the renewal process. The questions serve as a guide for standardizing a minimal set of data for physicians across all state boards.

1. What is your current employment status?
 - Actively working in a position that requires a medical license
 - Actively working in a field other than medicine
 - Not currently working
 - Retired

2. Are you currently providing direct clinical or patient care on a regular basis?
 - Yes
 - No
 - a. If no, how many years has it been since you provided clinical or patient care?
 - Less than 2 years
 - 2 to 5 years
 - 5 to 10 years
 - More than 10 years

3. Which of the following best describes the area(s) of practice in which you spend most of your professional time:

Area of Practice	Principal	Secondary	Completed Accredited Residency Program or Fellowship
Adolescent Medicine	0	0	0
Anesthesiology	0	0	0
Allergy and Immunology	0	0	0
Cardiology	0	0	0
Child Psychiatry	0	0	0
Colon and Rectal Surgery	0	0	0
Critical Care Medicine	0	0	0
Dermatology	0	0	0
Endocrinology	0	0	0
Emergency Medicine	0	0	0
Family Medicine/General Practice	0	0	0
Gastroenterology	0	0	0
Geriatric Medicine	0	0	0
Gynecology Only	0	0	0
Hematology & Oncology	0	0	0
Infectious Diseases	0	0	0
Internal Medicine (General)	0	0	0
Nephrology	0	0	0
Neurological Surgery	0	0	0
Neurology	0	0	0
Obstetrics and Gynecology	0	0	0
Occupational Medicine	0	0	0
Ophthalmology	0	0	0
Orthopedic Surgery	0	0	0
Other Surgical Specialties	0	0	0
Otolaryngology	0	0	0
Pathology	0	0	0
Pediatrics (General)	0	0	0
Pediatrics Subspecialties	0	0	0
Physical Med. & Rehab.	0	0	0
Plastic Surgery	0	0	0
Preventive Medicine/Public Health	0	0	0
Psychiatry	0	0	0
Pulmonology	0	0	0
Radiation Oncology	0	0	0
Radiology	0	0	0
Rheumatology	0	0	0
Surgery (General)	0	0	0
Thoracic Surgery	0	0	0
Urology	0	0	0
Vascular Surgery	0	0	0
Other Specialties	0	0	0

4. Which of the following categories best describes your primary and secondary practice or work setting(s) where you work the most hours each week?

Practice Setting	Principal	Secondary
Office/Clinic—Solo Practice	<input type="radio"/>	<input type="radio"/>
Office/Clinic—Partnership	<input type="radio"/>	<input type="radio"/>
Office/Clinic—Single Specialty Group	<input type="radio"/>	<input type="radio"/>
Office/Clinic—Multi Specialty Group	<input type="radio"/>	<input type="radio"/>
Hospital—Inpatient	<input type="radio"/>	<input type="radio"/>
Hospital—Outpatient	<input type="radio"/>	<input type="radio"/>
Hospital—Emergency Department	<input type="radio"/>	<input type="radio"/>
Hospital—Ambulatory Care Center	<input type="radio"/>	<input type="radio"/>
Federal Government Hospital	<input type="radio"/>	<input type="radio"/>
Research Laboratory	<input type="radio"/>	<input type="radio"/>
Medical School	<input type="radio"/>	<input type="radio"/>
Nursing Home or Extended Care Facility	<input type="radio"/>	<input type="radio"/>
Home Health Setting	<input type="radio"/>	<input type="radio"/>
Hospice Care	<input type="radio"/>	<input type="radio"/>
Federal/State/Community Health Center(s)	<input type="radio"/>	<input type="radio"/>
Local Health Department	<input type="radio"/>	<input type="radio"/>
Telemedicine	<input type="radio"/>	<input type="radio"/>
Volunteer in a Free Clinic	<input type="radio"/>	<input type="radio"/>
Other (specify):	<input type="radio"/>	<input type="radio"/>

5. How many weeks did you work in medical related positions in the past 12 months?

6. For all medical related positions held in (insert state name), indicate the average number of hours per week spent on each major activity:

Clinical or patient care	_____ hours/week
Research	_____ hours/week
Teaching/Education	_____ hours/week
Administration	_____ hours/week
Volunteering (medical related only)	_____ hours/week
Other (specify): _____	_____ hours/week

Another approach to obtaining this information would be to ask licensees: (1) number of weeks worked in the past 12 months, (2) average number of hours worked per week, and (3) the percentage of time per week spent on each major activity (e.g., clinical or patient care, research etc.).

7. What is the location of the site(s) where you spend most of your time providing direct clinical or patient care? Please enter the complete address for up to three locations and your direct patient care hours per week at each site.

(The workgroup strongly recommends collecting full addresses if all possible, but zip codes only would be acceptable for a minimal data set.)

Principal Location Address

Number	Street	

City/Town	State	Zip Code: □□□□□
Direct patient care hours per week at site: _____		

Second Location Address

Number	Street	

City/Town	State	Zip Code: □□□□□
Direct patient care hours per week at site: _____		

Third Location Address

Number	Street	

City/Town	State	Zip Code: □□□□□
Direct patient care hours per week at site: _____		

8. What is your sex?

- Male
- Female

9. What is your race? (1 or more categories may be selected)—Recommended as Optional

- White
- Black or African American
- American Indian or Alaska Native
- Asian
- Native Hawaiian/Other Pacific Islander
- Other (specify)

The workgroup acknowledges that this is a condensed list and state boards may choose to use more detailed response sets (e.g., HHS Data Standards for Race and US Census Bureau Race Categories).

10. Ethnicity: Are you Hispanic, Latino/a, or of Spanish origin?

(1 or more categories may be selected)—Recommended as Optional

- No
- Yes, Mexican, Mexican American, Chicano/a
- Yes, Puerto Rican
- Yes, Cuban
- Yes, Another Hispanic, Latino/a, or of Spanish origin (specify)

11. Do you speak a language other than English at home? (optional)

- a. Yes
- b. No

12. What is this language? (if you answered Yes to #11)

- a. Spanish
- b. Other Language (identify)

CONCLUSION

The MDS Workgroup believes that state medical boards can play a vital role in helping to accurately determine the size, distribution and demographic make-up of the physician workforce in the United States. The type of medicine physicians practice and how the services they provide impact patients in their areas is just as important and better data is needed on the geographic distribution of physician supply to target state and federal resources designed to help ensure access. The MDS Workgroup believes that state boards have a unique opportunity to contribute to accurate workforce planning by collecting physician demographic and practice information at the time of license renewal. Uniformity of a basic set of questions asked across multiple jurisdictions at the time of license renewal would yield a better understanding of whether the supply of physicians can meet the needs of a growing and aging population.

The MDS Workgroup recommends that the 2012 FSMB House of Delegates support and adopt the recommended framework for a uniform minimal physician data set. It is recognized that there may be challenges to implementation of a minimal physician data set. However, the MDS Workgroup believes that the framework is feasible, reasonable, consistent with the resolution adopted by FSMB's House of Delegates in May 2011, and suitable for use by state medical boards. Furthermore, the MDS Workgroup believes that the FSMB can and should commit to a leadership role by providing state boards resources to help them implement a minimal physician data set.

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Report of the
Special Committee on
Reentry to Practice

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EXECUTIVE SUMMARY

In 2010, the Federation of State Medical Boards (FSMB) formed a Special Committee on Reentry to Practice and charged it with issuing recommendations to the FSMB Board of Directors concerning physician and physician assistant reentry to the clinical practice of medicine. It is reported that a growing number of physicians have or will take a temporary leave from the practice of medicine. Physicians may take a temporary leave from practice for multiple reasons, including personal lifestyle decisions, or to pursue research, administrative or other professional interests not involving the clinical practice of medicine.

Regardless of the reasons for an interruption in clinical practice, it is critical for state medical and osteopathic boards (hereafter referred to as state member boards or SMBs), to address physician and physician assistant reentry as part of their mission to insure patient safety. As part of this mission, state member boards should provide a standardized process for physicians and physician assistants, who may take a temporary leave from practice, to demonstrate their competence prior to reentering practice. State member boards should also be aware that physician reentry may offer an additional means of addressing the anticipated national physician shortage.

The Special Committee recognizes that physician reentry can be a normal aspect of a physician's career. The Special Committee believes that concepts and standards for physician reentry should be consistent with lifelong learning expectations for all physicians, which include reflective self-assessment, assessment of knowledge and skills, and performance in practice.

In formulating this report, the Special Committee reviewed existing reentry activities and programs of state member boards, sought guidance from published literature, and consulted with other advisors. The Special Committee identified key reentry issues, and has developed 12 Reentry Guidelines.

The goal of the Special Committee's Report and 12 Reentry Guidelines are to provide to the FSMB and its state member boards a framework of common standards and conceptual processes for physician and physician assistant reentry. The Special Committee has purposefully linked its recommendations to discussions and activities regarding Maintenance of Licensure (MOL), the American Board of Medical Specialties (ABMS) Maintenance of Certification (MOC), and the American Osteopathic Association and Bureau of Osteopathic Specialists' (AOA BOS) Osteopathic Continuous Certification (OCC).

The Special Committee recommends 12 Reentry Guidelines to the FSMB. These guidelines are organized as follows:

- Education and Communications Issues
- Determining Fitness to Reenter Practice
- Mentoring Practitioners Who Want to Reenter the Workforce
- Improving Regulation of Licensed Practitioners Who Are Clinically Inactive
- The Relationship between Licensure and Specialty Certification

For state member boards, implementation of the Special Committee's Reentry Guidelines may require review and revision of existing medical and osteopathic practice acts, consideration of staffing, costs and resource issues, modification of license application and renewal forms, integration of reentry with MOL activities, and initiation of proactive communications with prospective and current licensees and applicants.

INTRODUCTION AND CHARGE

Freda Bush, MD, Immediate Past Chair of the FSMB Board of Directors, recently stated: “The question of how physicians reenter the practice of medicine after an extended absence for a significant period of time has always been important – and challenging – to SMBs. Ensuring physicians are qualified to reenter practice after a period of clinical inactivity is a complex process, which involves close coordination of education, testing, monitoring and regulation.”¹

The Federation of State Medical Boards (FSMB) Special Committee on Reentry to Practice was convened in the late summer of 2010. The Committee was charged with issuing recommendations to the FSMB Board of Directors concerning physician and physician assistant reentry to the practice of medicine as outlined below.

1. Review and evaluate the recommendations relative to reentry in the Special Committee on Maintenance of Licensure as contained in its 2008 draft report;²
2. Review and evaluate the policies, procedures and other mechanisms currently used by state member boards to oversee physicians and physician assistants in reentering the active practice of medicine;
3. Review and evaluate the work to date on issues related to reentry to practice from medical professional organizations and other entities, including the AMA, AOA, AAP, et al;
4. Review and evaluate the FSMB’s recommendations related to Maintenance of Licensure (MOL) and its implementation and develop recommendations as to how MOL requirements can be aligned with reentry to practice requirements;
5. Establish and recommend guidelines that state member boards can utilize to determine the competence of physicians who have been out of clinical practice for a significant period of time for non-disciplinary reasons;
6. Provide guidance about the potential application of guidelines developed as part of #5, to disciplinary, impairment or retraining issues that may be associated with reentry.

Recognizing that physician reentry is becoming a common career trajectory and a normal part of a physician’s continuing practice of medicine, the goal of the Special Committee’s Report is to provide to the FSMB and its state member boards a framework of common standards and conceptual processes for physician and physician assistant reentry.

Reentry programs are consistent with lifelong learning expectations for physicians and there is some evidence that physicians who participated in a supportive, structured educational program were generally successful in achieving their goal of restoring licensure and returning to practice.³

Although reentry affects a broad spectrum of health care providers, the Special Committee’s intent is to make its recommendations useable for physicians and physician assistants. Implementation of the Special Committee’s recommendations should result in a reentry process that is appropriately comprehensive, but practical and flexible enough to address a variety of situations and specialties. The Special Committee also specified that its report should provide common standards and conceptual processes for state member boards to implement the recommendations, and not necessarily be a specific “tool box” at this point. They agreed that important outcomes would be to fulfill SMBs’ mission of ensuring public safety, an increase in public confidence in physicians and their licensing boards,

enhanced communications between SMBs and physicians about the implications of what taking a leave from practice means and increased awareness of how physicians should prepare for such an event.

The Special Committee developed a description of desired outcomes for this project and the audience, scope and organization of the report. This information is contained in Attachment A. A glossary is included in Attachment B. Attachment C provides a listing of barriers to reentry as developed by The Physician Reentry into the Workforce Project of the American Academy of Pediatrics. Attachment D is a summary of the FSMB policy on Maintenance of Licensure, which is referred to frequently in this report. Attachment E provides a number of resources from state member boards that are intended to provide practical assistance on reentry. Attachment F provides references for additional literature on reentry.

NEED FOR REENTRY GUIDELINES FOR STATE MEMBER BOARDS

It is reported that a growing number of physicians are making the decision to take leave from the clinical practice of medicine, with many seeking to return at some future point⁴. Physicians may take a break from practice due to family responsibilities or they may decide to temporarily focus on research or administrative careers not involving the everyday practice of medicine. Other reasons physicians take time off from clinical practice include birth of a child, child care, caring for an ill family member, personal health, military service, humanitarian leave, and change in career path and career dissatisfaction.⁵

Regardless of the reasons for an interruption in practice, it is critical for SMBs to address reentry for the following reasons:

- To advance patient safety and quality of care;
- For SMBs to provide a standardized process for physicians and physician assistants, who may take a temporary leave from practice, to demonstrate their competence prior to reentering practice;
- For physicians who leave practice and do not reenter, there is:
 - A loss of physician contributions to the health care delivery system;
 - A worsening of the current access problems, especially in underserved areas;
 - The forfeiture of the investment in medical education and specialty/subspecialty training;
- Reentry to practice may offer an additional and more cost-effective means of addressing the anticipated national physician shortage and/or responding to national or local emergencies, such as natural disasters.

Several SMBs have already addressed reentry in response to the above points in order to assure citizens of their respective states that physicians who leave clinical practice are qualified to return. There is research that indicates that physicians who have been out of practice a certain number of years lose their skills.⁶ With the emphasis on outcomes measurement in health care reform, it is anticipated that there will be increased demand for programs of quality assessment for those in practice as well as those reentering it.

SMBs are also concerned that Maintenance of Licensure (MOL) requirements^{7, 8} and the ongoing rollout of American Board of Medical Specialties Maintenance of Certification (ABMS MOC) and the American Osteopathic Association Bureau of Osteopathic Specialists (AOA BOS) Osteopathic Continuous Certification (OCC) requirements may uncover a significant number of physicians who are not in active

clinical practice. The same activities that physicians may need to meet MOL and specialty board certification requirements should also be used as part of a reentry process. SMBs are anticipating that there will be a link between MOL/MOC/OCC and Performance in Practice requirements, and reentry guidelines are needed to avoid unnecessary duplication.

Finally, there are a host of barriers for physicians who want to reenter practice (see Attachment C for a listing developed by the American Academy of Pediatrics Physician Reentry Project). The FSMB, working with its state member boards, can develop a more unified system to help address and reduce those barriers to reentry.

There are concerns that Maintenance of Licensure and certification requirements will identify a significant number of physicians who will need reentry activities. There is also anecdotal evidence that the problem is increasing in part because of economic and demographic changes among physicians. It appears that there are increasing numbers of retired physicians who desire to return to practice to augment their incomes during the current economic recession.⁹ With women comprising a larger percentage of the physician workforce, they often, although not exclusively, may take on responsibilities of childbirth, childcare, and caring for an ill or elderly family member.¹⁰

KEY REENTRY ISSUES

Physician reentry into clinical practice can be defined as returning to professional activity/clinical practice for which one has been trained, certified or licensed after an extended period.¹¹ Reentry is an issue that cuts across genders and specialties. However, anecdotal evidence indicates that reentry into the workforce affects women more often than men.¹² Although there is paucity of data on this complex topic, many agree that it is an issue that is gaining prominence,¹³ and is crucial to continuing public safety.

The Special Committee identified several key issues to be addressed during its work. The following list is neither exhaustive nor in an order of priority.

- **Timeframe:** More than two years away from practice is commonly accepted as the timeframe for when physicians should go through a reentry process. The two-year timeframe is based on a 15-year-old FSMB policy, but further information is needed. In the absence of data, the Committee recognizes the need for flexibility when applying the two-years-away-from-practice timeframe to an individual practitioner, as there is great variability in specialty, type of practice, etc.
- **Data Needs:** More data are needed to know how many physicians are impacted by reentry issues. Information about how many physicians are clinically inactive but maintain an active license to practice is needed. The number of physicians who have been out of practice and have sought or are currently seeking reentry is needed. Although data are lacking, the Committee believes that anecdotal evidence speaks to the need for reentry interventions and that a growing number of physicians will need reentry tools and programs.
- **SMB Data Collection:** There is an urgent need for SMBs to add questions to their license renewal applications in order to help determine the status of physicians and the magnitude of the reentry problem.

- **Congruence with Maintenance of Licensure and Maintenance of Certification:** SMBs need to ensure that licensees and applicants are ready to reenter after a period of inactivity. However, as SMBs design or redesign their reentry programs, they should allow activities that physicians may need to meet MOL and specialty board certification requirements to satisfy the reentry process.
- **Barriers to Reentry:** There are difficulties associated with identifying entities that provide reentry services to physicians. Cost, geographic considerations, eligibility requirements, licensure, malpractice issues and lack of uniformity among alternatives available to physicians seeking reentry are problematic.
- **Mentors of Reentry Physicians:** The availability of physician mentors and the processes of vetting their skills, paying them for their work, and defining the types of tools they should use in assisting those physicians who are on a reentry path are considerations that need to be addressed.
- **Role of Academic Medical Centers (AMCs) and Community Hospital Training Centers:** Because they already have the facilities and resources, AMCs could play multiple roles in the reentry process. They could provide a complete reentry package from initial assessment of the reentry physician to his or her final evaluation of competence and performance in practice. Academic Medical Centers could provide selected services on an as-needed basis such as assessment testing, focused practiced based learning, procedure labs and providing and vetting mentors. Potential incentives to stimulate AMC involvement in reentry include research opportunities and generation of revenue.
- **Resources for Funding:** There is a need for funding to help cover the costs of physician reentry. Federal, state and local funding driven by physician shortages may become a funding source. Potential employers, including community hospitals and large group practices, may be willing to offset individual physician reentry costs in exchange for later service. There is a challenge to creatively find new funding, both nationally and locally, and promote its availability.
- **Medical Liability Insurance:** Better understanding is needed about how malpractice coverage works when physicians leave and when they reenter practice. It would also be helpful to know how coverage for mentoring physicians is handled.
- **Maintaining Licensure if Not in Active Clinical Practice:** SMBs are facing the question of whether physicians who are not in active clinical practice should be allowed to maintain an active license. Some states consider the work done and decisions made by medical directors of health care programs to be the practice of medicine and therefore they are required to have an active license. Other states recognize administrative medicine as a distinct area of practice and issue full and unrestricted licenses to administrative physicians with the expectation that administrative physicians, like all other licensees/applicants, appropriately limit their practice to areas where they are competent.
- **Retraining When Practice Differs or is Modified from Area of Primary Training:** Some physicians who seek reentry want to practice in a specialty or area that differs from their area of primary training. For example, an obstetrician/gynecologist may wish to practice family medicine. Another example is when a physician seeks to modify his or her primary area of practice, such as when an

obstetrician/gynecologist seeks to only practice gynecology. It is uncertain how much, if any, additional training might be needed for these types of physicians.

- **Simulation:** Simulations will play an important role in the future because they replicate cognitive and procedural skills and simulate team interaction. How can reentry activities take advantage of simulation centers and also pay for the services these centers might provide?

INPUT FROM ADVISORS

As part of its work, the Committee invited several professionals experienced in reentry to help inform its opinions and recommendations via two webinars. These presenters, which included representatives from previously or currently active reentry programs, had firsthand experience with physician reentry programs and were willing to discuss their experiences. The Committee would like to thank: Robin Wooton, Executive Director, Society for Simulation in Health Care (SSH); Barry Manuel, MD, Associate Dean, Professor of Surgery, Boston University School of Medicine; Elizabeth J. Korinek, MPH, Board Member, Coalition for Physician Enhancement (CPE); and Joann Baumer, MD, John Peter Smith Hospital in Ft. Worth, Texas.

The participants discussed several issues including costs, effectiveness and need for reentry programs. Some specific considerations involved:

Costs: It appears that, depending on design, costs for participating in and completing a formal reentry program can range from \$5,000-\$20,000 per individual participant. For those who have been ill, taken family medical leave, or for those in primary care specialties, limited funds can make program costs especially prohibitive.

Need for Programs: It appears that currently the number of participants is relatively small. For example, approximately 30 physicians are participating in a three-year period at one program and approximately 60 are completing another six-month university program.

Program Completion: It appears that most physicians who begin the programs complete them successfully, although one program found through prescreening that 20-30% were judged not to have the capacity to complete the program.

Programs Tailored to Individuals: All of the presenters agreed that it was desirable to have flexible programs that addressed the tremendous variety of individual needs.

Two-Year Minimum: It was agreed that there is a need for a commonly accepted “out of practice” timeframe for physician reentry.

ROLE OF STATE MEMBER BOARDS IN REENTRY

The Special Committee recognizes that several state member boards have strong policy and significant experience with the reentry process. The North Carolina Medical Board, for example, has supervised the reentry of approximately 60 physicians and 40 physician assistants. The Special Committee noted that Oregon, Massachusetts, and others have reentry rules (see Attachment E for examples). Based on

this experience, there appear to be a number of roles that state member boards can play in the process. For example, state member boards may:

- Develop a policy and provide advice to those desiring to reenter.
- Proactively identify those who are not complying with MOC or MOL requirements and inquire about their practice status and advise them of how to reenter.
- Notify all applicants/licensees about what they should do in advance of taking a leave from the practice of medicine in order to avoid future reentry problems.
- Directly supervise the reentry process using Board staff, while others will rely on programs in place for this purpose or academic medical centers
- Cooperate, perhaps on a regional basis, to best serve licensees/applicants and make best use of limited resources.
- Facilitate or support programs at academic medical centers in their state or region.

Recently, Nebraska enacted a law to provide for reentry licenses under its Medicine and Surgery Practice Act. Upon recommendation of the state board, a physician who has not been actively practicing medicine for the two-year period immediately preceding, or who has not otherwise maintained continued competency during such period as determined by the board, may qualify for a reentry license, which can then convert to a regular license after completion of assessment and supervised practice.

SUGGESTED REENTRY GUIDELINES*

The following 12 guidelines are intended to help SMBs facilitate a physician's reentry to practice while simultaneously ensuring the public is protected. Building on the FSMB's work in Maintenance of Licensure (MOL), the Special Committee believes that for individual physicians the reentry process should segue into MOL. Whenever possible, the three MOL components (Reflective Self-assessment, Assessment of Knowledge and Skills, and Performance in Practice) have been included as part of the reentry process.

While some of the guidelines contained herein may be appropriate for physicians whose absence is due to disciplinary or impairment reasons, the guidelines are primarily intended to address situations where a physician has taken a voluntary leave of absence. For purposes of this report, the recommendations apply to both physicians and physician assistants.

The Special Committee discussed the issue of impaired physicians and how the following guidelines might affect them and their SMBs. After a review of the FSMB Policy on Physician Impairment, which was adopted by the FSMB as policy in 2011, it was decided that these guidelines do not conflict with the FSMB policy and, in fact, enhance it.¹⁴ It is suggested that SMBs use these guidelines on Physician Reentry to augment their programs and to convey the importance of a reentry plan to the physicians participating in an Impaired Physician Program.

**This section is adapted from the draft final report of the Special Committee on Maintenance of Licensure (2008).*

Education and Communication Issues

Guideline 1: Proactive Communications

To help prepare licensees/applicants who either are thinking about taking a leave of absence or are considering returning to clinical practice, SMBs should proactively educate licensees/applicants about the issues associated with reentering clinical practice (e.g., continued participation in CME activities while out of practice, unintended consequences of taking a leave of absence such as impact on malpractice costs and future employment).¹⁵ For example, SMBs could develop written guidance on issues like the importance of engaging in clinical practice, if even on a limited, part-time basis, or seeking counsel from their insurance carriers prior to withdrawal from practice and when they are ready to reenter practice. They might also suggest that the licensee/applicant consult the Inventory created by the Physician Reentry to the Workforce Project (www.physicianreentry.org).¹⁶ State member boards could include such information with the initial license, with the license renewal application, in the board's newsletter and on the board's website.

Guideline 2: Flexibility

The medical community will have to determine how to make the system flexible enough to accommodate reentering practitioners whose personal lives or professional goals interfere with the ability to remain clinically active. All entities that depend on physicians to provide clinical care should be encouraged to accommodate individuals who are interested in returning to clinical practice but who may need flexible or part-time scheduling. A recent study concluded that the lack of opportunities for part-time work and flexible scheduling may preclude some who otherwise would reenter practice from returning to practice.¹⁷ This systemic issue is difficult for SMBs to address, but it remains a significant issue.

Determining Fitness to Reenter Practice

It is the responsibility of SMBs to determine whether a licensee/applicant who has had an interruption in practice should demonstrate whether he or she is competent to return to practice. Of the 30 boards that have a reentry policy, a majority use a two-year continuous interruption in practice as an indicator for the need for a reentry activity, although requirements range from one to five years.¹⁸ The FSMB recommends that for licensure by endorsement, SMBs should adopt a flexible approach based on an applicant's individual needs, and guidelines established by the licensee/applicant specialty society or specialty board. SMBs may be guided by the concept that those who have not been in active practice for the previous 24-month period may be required to demonstrate their continued competence. Despite SMB requirements and FSMB recommendations, little research is available to inform discussions about how time away from clinical practice impacts competence.

Guideline 3: Case-by-Case Basis

Because competence is maintained in part through continuous engagement in patient care activities, licensees/applicants seeking to return to clinical work after an extended leave should be considered on a case-by-case basis. Decisions about whether the licensee/applicant should demonstrate readiness to reenter practice should be based on a global review of the licensee/applicant's situation, including

length of time out of practice, what the practitioner has done while away from practice, the licensee/applicant's prior and current or intended area of specialization, prior disciplinary history, hospital privilege reports, and the licensee/applicant's participation in continuing medical education and/or volunteer activities during the time out of practice. Licensees/applicants who wish to take some time away from clinical practice should be encouraged to remain clinically active in some, even if limited, capacity, and urged to participate in continuing medical education and MOC, OCC, National Commission on Certification of Physician Assistants (NCCPA) certification maintenance processes and MOL activities if available.

Guideline 4: Documentation

All licensees/applicants returning to clinical practice after a period of inactivity should be required to provide a detailed description of their future scope of practice plans. The degree of documentation required may vary depending on the length of time away from clinical practice and whether the licensee/applicant's scope of practice is consistent with his or her medical education and training. For example, documented evidence might include CME certificates and verification of volunteer activities.

The Special Committee distinguishes between the need for reentry and the need for retraining. A physician returning to a scope or area of practice in which he/ she is previously trained or certified, or in which he/ she previously had an extensive work history may need reentry. A physician returning to clinical work in an area or scope of practice in which he or she has NOT previously trained or certified or in which he/ she has NOT had an extensive work history needs retraining and, for the purposes of this report, is not considered a reentry physician. Because the licensee/applicant's intended scope of practice may not be the same as the specialty in which he/ she is trained or board certified, the reentering licensee/applicant should also be required to provide information regarding the environment within which they will be practicing, the types of patients they anticipate seeing, and the types of clinical activities in which they will be engaged.

Guideline 5: Reentry Plan

Licensees/applicants who have been clinically inactive should become involved in a reentry plan approved by the state member board before reentering the workforce. The reentry plan should include three fundamental components: reflective self-assessment by the licensee/applicant, assessment of the licensee/applicant's knowledge and skills, and the licensee/applicant's performance in practice as defined by the FSMB requirements for Maintenance of Licensure.¹⁹

State member boards should approve the elements and scope of the reentry plan prior to its initiation. Subsequently, the licensee/applicant should be required to present the outcomes of the reentry plan to the state member board.

If the licensee/applicant has not previously implemented a reentry plan, then SMBs may be authorized as needed to use non-punitive, time-limited license mechanisms to return a practitioner's license to active, unrestricted status. Such a mechanism permits the licensee/applicant to participate in activities necessary to regain the knowledge and skills needed to provide safe patient care, such as participation in a mini-residency.

5a: Reflective Self-assessment

Reentry documentation should reflect the licensee/applicant's participation in assessment and/or self-reflection activities with subsequent successful completion of educational activities tailored to address weaknesses or deficiencies identified through the assessment. These activities should be congruent with Component One of the FSMB MOL Framework. (See Attachment D) Continuing medical education activities presented by the licensee/applicant in support of his/ her competence should be relevant to the area of practice in which the licensee/applicant intends to engage and should be certified by an agency acceptable to the state member board.

5b: Assessment of Knowledge and Skills

Congruent with MOL Component Two: Assessment of Knowledge and Skills, state member boards should require licensees to undertake objective knowledge and skills assessments to identify learning opportunities and guide improvement activities.

SMBs should provide guidance about the appropriate content of a reentry plan. For example, SMBs could ask licensees/applicants to provide the results of their self-assessment, the processes used to assess knowledge and skills, and the means by which performance in practice was evaluated. Other appropriate content should include the qualifications of the mentoring physician, information from the mentor about the licensee/applicant's clinical duties and responsibilities, location of the practice, approximate number of hours worked, patient volume and acuity, procedures done, results of chart audits, method of mentoring, and frequency of direct observation.

Documentation of such activities should be required. For example, mentors should be sufficiently vetted to participate with the licensees/applicants' process of assessment. There are also recognized assessment programs that are available and could be an option for meeting this requirement.

5c: Performance in Practice:

Consistent with MOL Component Three: Performance in Practice, licensees/applicants should also be required to provide documentation showing their satisfactory performance in practice as part of a reentry plan. Qualifying activities could include a variety of methods that incorporate reference data to assess physician performance in practice as a guide to improvement. Potential resources that may be used to specifically address the component include standardized testing (e.g., SPEX, COMVEX, other), practice mentors, chart audits, "mini-residencies," individualized, tailored continuing medical education and evaluation by a formal assessment program, or other equivalent activities.

Guideline 6: SMB Collaborative Relationships

State member boards should foster collaborative relationships with academic institutions, community hospital training centers and specialty societies within their jurisdictions to develop assessment, educational and other interventions and resources for the various types of practices. The National Board of Osteopathic Medical Examiners, the National Board of Medical Examiners, the American Board of Medical Specialties, and the American Osteopathic Association Bureau of Osteopathic Specialties may likewise serve in a supportive role to state member boards in this regard. These institutions and organizations may have readily adaptable programs or simulation centers that meet the individual needs of reentering physicians.

Mentoring for Practitioners Who Want to Reenter the Workforce

Guideline 7: Board-approved Practice Mentors

Practice mentors may be selected by either the state member board or the licensee/applicant, but in all cases should be approved by the state member board. At a minimum, the practice mentor should be ABMS or AOA board certified and practice in the same clinical area as the licensee/applicant seeking reentry.

The state member board should set forth in writing its expectations of the practice mentor, including what aspects of the reentering licensee/applicant's practice are to be mentored, frequency and content of reports by the mentor to the state member board and how long the practice is to be mentored. The board's expectations should be communicated both to the mentor and the licensee/applicant being mentored. For physician assistants, the role of practice mentor may be fulfilled by the supervising physician.

The practice mentor should be required to demonstrate to the board's satisfaction that he/ she has the capacity to serve as a practice mentor, for example, sufficient time for mentoring, lack of disciplinary history, proof of an active, unrestricted medical license, and/or demonstration of a prescribed number of years in clinical practice. The practice mentor may be permitted to receive financial compensation or incentives for work associated with practice mentoring. Potential sources of bias should be identified and in some cases may disqualify a potential mentor from acting in that capacity.

State member boards should work with the state medical and osteopathic societies and associations and the medical education community to identify and increase the pool of potential practice mentors. For example, to protect the pool of mentors, some SMBs have made them agents of the board.

Guideline 8: Transition to a Full Unrestricted License

Physicians and physician assistants who have gone through a reentry process and receive a full, unrestricted license should then be subject to the same rules and regulations as other licensees.

Improving Regulation of Licensed Practitioners Who Are Clinically Inactive

State member boards should implement the following mechanisms to improve regulation of licensed practitioners who are clinically inactive but may return to clinical practice in the future.

Guideline 9: Identifying Clinically Inactive Licensees

State member boards should require licensees to report information about their practice as part of the license renewal or registration process, including: type of practice, status (e.g., full-time, part-time, number of hours worked per week), whether they are actively seeing patients, specialty board certification status, and what activities they are engaged in if they are not engaged in clinical practice (e.g., research, administration, non-medical work, retired, etc.). Such information will enable SMBs to identify licensees who are not clinically active and to intervene and guide, as needed, if and when a licensee chooses to return to patient care duties. State member boards should advise licensees who are

clinically inactive of their responsibility to participate in an individualized, diagnostic reentry plan prior to resuming patient care duties.

The report of the FSMB Workgroup to Define Minimal Data Set is expected to provide additional recommendations regarding a minimal physician demographic data set that state member boards should collect as part of the licensure process. In addition, the report of the FSMB Maintenance of Licensure Workgroup on Non-Clinical Physicians is expected to provide recommendations regarding how non-clinically active physicians may participate in a state member board's MOL program and how participation in such a program should be evaluated at the time of reentry to clinical practice.

Guideline 10: Licensure Status

Licensees who are clinically inactive should be allowed to maintain their licensure status as long as they pay the required fees and complete any required continuing medical education or other requirements as set forth by the board. Upon a licensee's decision to return to clinical practice, he or she should be required to participate in a reentry process.

Guideline 11: Consistency of Reentry across Jurisdictions

State member boards should be consistent in the creation and execution of reentry processes. In recognition of the differences in resources, statutes and operations across states and acknowledging that implementation of physician reentry should be within the discretion and purview of each SMB, these guidelines are designed to be flexible to meet local considerations. At the same time, physicians may be concerned about an overly burdensome reentry process where they might have to meet varying criteria to obtain licensure in different states. For purposes of license portability, FSMB should coordinate the implementation of these guidelines so there is as much consistency as possible.

Relationship between Licensure and Specialty Certification

A physician's ability to maintain specialty board certification during a leave of absence will depend on whether the physician has voluntarily allowed his or her license to lapse. The 24 boards of the American Board of Medical Specialties (ABMS) have implemented Maintenance of Certification (MOC) programs, which require, in part, the physician's ability to demonstrate good professional standing by virtue of having a full and unrestricted license. In addition, the American Osteopathic Association Bureau of Osteopathic Specialists (AOA BOS) is implementing an Osteopathic Continuous Certification (OCC) program, which also requires, in part, demonstration of a full and unrestricted license.

Guideline 12: Maintenance of Specialty Certification

In situations where a licensed, board certified physician is returning to clinical practice, state member boards should make every effort to ensure that any conditions for the physician's reentry to practice do not hinder the physician's ability to maintain specialty certification.

IMPLICATIONS FOR STATE MEMBER BOARDS AND THE ROLE OF FSMB

The Special Committee on Reentry to Practice discussed possible implications of reentry on SMBs and the role of the FSMB in implementing the Special Committee's recommendations. For state member

boards, there will be a need to review and perhaps revise their medical practice acts, to consider staffing, costs and resource issues, to modify license application and renewal forms, to integrate reentry with MOL activities and to initiate proactive communications with prospective and current licensees/applicants.

To assist SMBs with implementing reentry requirements, FSMB should consider the following suggestions:

- FSMB should develop a uniform set of questions for SMBs to add to their license renewal application.
- Once guidelines are adopted as policy, FSMB should offer advice and consultation to their member boards.
- FSMB should commit to reviewing its reentry recommendations and policy every three to five years to ensure it remains current.
- FSMB could develop standards for language, forms and checklists to assist in implementation. For example, FSMB could provide sample guidance on issues like the importance of engaging in clinical practice, if even on a limited and part-time basis, or seeking counsel from their insurance carriers prior to withdrawal from practice.
- FSMB can help share best practices, information and resources across states through conferences, the FSMB Annual Meeting, publications and web-based reporting tools.

CONCLUSION AND NEXT STEPS

Widespread and well-defined physician reentry processes will probably not be fully realized nationwide for several years. During that time, the Special Committee recommends that FSMB launch a systematic effort to encourage states to share with each other what is working and what may need improvement in order to define best practices. Most immediately, there is a need to understand the magnitude of the problem.

As indicated in Guideline 9, state member boards should require licensees/applicants to report information about their practice as part of the license renewal or registration process. When these data are collected nationwide and reported, there will be a much stronger understanding of the opportunity to increase the physician and physician assistant workforce.

Secondarily, there is a significant need to develop an evidence base for reentry. Research is needed about the type and degree of assessment that is required to determine educational needs. Another question deserving study is the effectiveness of various types of reentry programs.

Finally, the short and long term results of reentry programs must be evaluated. Although there is evidence from the existing reentry programs that most physicians who begin a reentry program complete it successfully, more systematic research needs to be undertaken, especially regarding the two-year time frame precedent. Also, longer term follow up studies will be necessary to determine if those completing program make a successful transition to practice and what, if any, obstacles they may encounter.

SPECIAL COMMITTEE DESIRED OUTCOMES

The Special Committee agreed that its work should be focused on the following desired outcomes:

- The overall goal should be to establish physician reentry as a common career trajectory with an expectation that it is a normal part of a physician’s continuing practice of medicine.
- Although reentry affects a broad spectrum of health care providers, the Special Committee’s intent is to make its recommendations useable for physicians and physician assistants; implementation of the Special Committee’s recommendations should result in a reentry process that is rigorous, but practical and flexible enough to address a variety of situations and specialties.
- The report should provide common standards and conceptual processes for state member boards to implement the recommendations, and not necessarily be a specific “tool box” at this point.
- Recommendations from the Special Committee should increase public confidence in physicians and their licensing boards; the ideal would be for the recommendations to be linked to the enhancement of patient outcomes.
- An important outcome will be enhanced communications between SMBs and physicians about the implications of what taking a leave from practice means and increased awareness of how physicians should prepare for such an event.
- The Special Committee believes involvement of academic medical centers in reentry activities, including focused research on this topic, is highly desirable.
- The report should explicitly link reentry with Maintenance of Licensure (MOL), ABMS Maintenance of Certification (MOC), and AOA BOS Osteopathic Continuous Certification (OCC).

THE AUDIENCE, SCOPE AND ORGANIZATION OF THE SPECIAL COMMITTEE REPORT

The Special Committee discussed the nature of the report and provided the following guidance.

- The primary audience for the report will be state member boards, with the understanding that the report could be useful and easily adapted to the following secondary audiences of individuals and groups: physicians and physician assistants, students, residents, specialty organizations, hospital credentialing groups, national and state legislators and regulators, and the public.
- It will be important to establish the rationale for the work; the audience must be able to clearly understand why guidelines or pathways for state member boards are needed.
- The report should be of journal quality, media-worthy and also be clear and relevant to SMBs and their licensees/applicants, perhaps including diagrams and algorithms; perhaps a 10-page document with additional appendices.
- Clear definitions of what is meant by reentry, active practice and inactive practice, for example, should be provided in the glossary.

- The tone of the report should be positive and reinforce the concept that reentry is an accessible and professionally rewarding process.
- The report will focus on undifferentiated licenses and not address administrative licenses, which should be deferred until the FSMB Maintenance of Licensure Initiative progresses.
- The Committee also discussed whether its recommendations should address non-physician clinicians beyond physician assistants and decided that the recommendations will be available to other groups that could chose what to adopt for their use.

GLOSSARY

The following definitions were adapted from the AAP Physician Reentry into the Workforce Project, the AMA, the AOA, the American Board of Medical Specialties, and the FSMB Special Committee report on Maintenance of Licensure.

AMA Definition of Physician Reentry: A return to clinical practice in the discipline in which one has been trained or certified following an extended period of clinical inactivity not resulting from discipline or impairment; distinct from remediation or retraining.

AAP Definition of Physician Reentry: Returning to professional activity/clinical practice, for which one has been trained, certified or licensed after an extended period.

Clinically Active Practice: Clinically active status is defined as any amount of direct and/or consultative patient care that has been provided in the preceding 24 months. STANDARDS FOR ABMS MOC® (PARTS 1-4) PROGRAM, Approved March 16, 2009

Clinically Inactive Practice: No direct and/or consultative patient care that has been provided in the past 24 months. STANDARDS FOR ABMS MOC® (PARTS 1-4) PROGRAM, Approved March 16, 2009

Comprehensive Osteopathic Medical Variable-Purpose Examination (COMVEX): The evaluative instrument offered by the National Board of Osteopathic Medical Examiners for osteopathic physicians who need to demonstrate application of clinical knowledge for the practice of osteopathic medicine.

Education: The process whereby deficiencies in physician performance identified through an assessment system are corrected.

Impaired Physician: A physician who is unable to fulfill personal or professional responsibility because of psychiatric illness, alcoholism, or drug dependency.

Maintenance of Certification: In 2000, the 24 member boards of the American Board of Medical Specialties (ABMS) agreed to evolve their recertification programs to one of continuous professional development – ABMS Maintenance of Certification® (ABMS MOC®). ABMS MOC assures that the physician is committed to lifelong learning and competency in a specialty and/or subspecialty by requiring ongoing measurement of six core competencies adopted by ABMS and ACGME in 1999.

Maintenance of Licensure: Maintenance of Licensure is a system of continuous professional development that requires all licensed physicians to demonstrate, as a condition of license renewal, their involvement in lifelong learning that is objective, relevant to practice and improves performance over time.

Mentoring: a dynamic, reciprocal relationship in a work environment between two individuals where, often but not always, one is an advanced career incumbent and the other is a less experienced person. The relationship is aimed at fostering the development of the less experienced person. (Baucher H. Mentoring Clinical Researchers. Archives of Diseases of Children. 2002;86; 82-84.)

Osteopathic Continuous Certification: The American Osteopathic Association's Bureau of Osteopathic Specialists (AOA BOS) has mandated that each specialty certifying board implement "Osteopathic Continuous Certification" (OCC). OCC will serve as a way for board certified DOs can maintain currency and demonstrate competency in their specialty area. The American Osteopathic Association's seven core competencies are: 1) medical knowledge, 2) patient care, 3) practice-based learning and improvement, 4) interpersonal and communication skills, 5) professionalism, 6) systems-based practice, and 7) osteopathic philosophy and osteopathic manipulative medicine.

Physician Assistant Certification Maintenance Process: The National Commission on Certification of Physician Assistants is expanding its long-standing requirements of continuing medical education and regular retesting to include new self-assessment activities and performance improvement activities.

Physician Reentry Program: Structured curriculum and clinical experience which prepared physicians to return to clinical practice following an extended period of clinical inactivity.

Physician Reentry Program System: Provides a way of organizing and planning physician reentry programs.

Physician Retraining: The process of updating one's skill or learning the necessary skills to move into a new clinical area.

State Member Boards: State medical and osteopathic licensing boards that oversee the activities of the physicians licensed in the states, District of Columbia and U.S. Territories, assuring that a high standard of practice by the physicians is maintained. (Adapted from McGraw-Hill Concise Dictionary of Modern Medicine. © 2002 by The McGraw-Hill Companies, Inc.)

REENTRY BARRIERS
(from the Physician Reentry into the Workforce Project
of the American Academy of Pediatrics)

The Physician Reentry into the Workforce Project maintains that decisions to leave and then reenter the workforce should be regarded as part of a physician's career trajectory, and not as an unusual event. Physicians who are considering leaving clinical practice, as well as those who are planning to reenter, should understand and acknowledge that there can be barriers to this process. Not all physicians will encounter all or even most of these barriers on the following list, but it is wise to be prepared.

- Physician/Practitioner Factors:

- Lack of confidence and/or psychological concerns;
- Lack of knowledge and skills, both clinical and documentation skills (i.e., EMR experience);
- Lack of experience and comfort with other technological advances (i.e., internet searches, PDA use, etc.);
- Lack of knowledge of requirements, sometimes leading to decisions that cause difficulty in returning (such as allowing a license to lapse or become inactive);
- Failure to maintain knowledge in their clinical specialty because they do not anticipate a return to medicine;
- “Unconscious incompetence” – even though the practitioner may have tried to prepare, s/he may be unaware of or unable to anticipate all areas in which s/he needs to update; inability to self-assess educational needs relative to the needs of the prospective practice setting; personal feelings of adequacy or ability to practice medicine as needed;
- Pride: difficulty admitting that one is in need of further training;
- Lack of time to address the educational needs; and inability to plan for oneself how to address the needs;
- Difficulty determining when the educational gap is sufficiently addressed.

- Licensure and Licensing Board Factors:

- Failure to educate practitioners who allow their license to lapse of these requirements and potential consequences;
- Requirements that may be vague, arbitrary, and may have changed over time (or may in the future);
- Requirements that differ in vigor from state to state;
- Limited options given by which to demonstrate competence for any given state;
- Limited means available by which to demonstrate competence;
- Lack of understanding whether the options to demonstrate competence actually do so; lack of understanding of what can be used as a proxy for “competence”;
 - Often the criteria used is hands-on patient care in the U.S. (and the only criteria accepted by boards);
 - If criteria exist (such as the “two-year rules”) they often do not

differentiate between specialties. For example, perhaps “hands-on” care is more relevant for maintaining “competence” in surgical and procedural based specialties, and the critical time out period should be different for procedural and non-procedural specialties;

- Licensing organizations do not usually risk-stratify practitioners in deciding how a physician should prove competency after a time away (based on factors such as whether the practitioner is/was ever board certified, or whether the physician has required to recertify periodically, and has done so).

- Hospital and Other Privileging Bodies:

- Discomfort with and/or lack of willingness to allow privileges to a physician who has not been in recent clinical practice;
- Significant variations in this comfort level between hospitals (even for the same specialty);
- Varying ability to provide proctoring or work with physicians in a staged re-entry process (i.e., gradually lessening levels of supervision);
- Hesitance of managed care organizations and medical insurance companies to accept a re-entering physician onto their provider panel.

- Liability Coverage Factors:

- Discomfort with and/or lack of willingness to provide liability coverage to a physician who has not been in recent clinical practice;
- Significant variations in this comfort level between insurers and from individual to individual.

- Prospective Employer Factors:

- As with all the other levels, lack of understanding of how to judge competence of a clinician who does not have recent clinical experience;
- Limited availability of flexible work options;
- Lack of support from the institution and colleagues for those integrating back into the workplace.

- Reentry Program Factors:

- Discomfort with and lack of practicality in providing a “certificate of competence”;
- Variability in what each program can offer to the practitioner and offer to the prospective board/hospital/malpractice insurer, etc.
- Limited availability of sites where re-entry programs can provide hands on clinical experiences for physicians because of the above factors;
- Cost of and distance to established programs; need for convenient and affordable programs;
- Need for flexible programs;

- Lack of standardization of how these evaluations are done and/or reentry process is conducted.
- Home and Family Barriers:
 - Ongoing needs such as childcare and needs of other family/household members;
- Multi-level Factors:
 - Multiple different layers of regulating and certifying bodies with different criteria for demonstration of aptitude and proficiency (which may or may not equate to competence), all of which the practitioner must fulfill; for example, requirements to maintain specialty board certification are not considered adequate demonstration of competence by boards and licensing authorities;
 - Unclear who is/should be the decision-maker in such matters;
 - Need for counseling to provide direction regarding the kind of learning and training needed.

For more information on The Physician Reentry into the Workforce Project visit www.physicianreentry.org

Physician Reentry into the Workforce Project. Issue Brief: Reentry Barriers. Elk Grove Village, Ill. American Academy of Pediatrics; 2010.

FSMB MAINTENANCE OF LICENSURE FRAMEWORK

As a condition of license renewal, physicians should provide evidence of participating in a program of professional development and lifelong learning that is based on the general competencies model:

- medical knowledge
- patient care
- interpersonal and communication skills
- practice based learning
- professionalism
- systems based practice

The following requirements reflect the three major components of what is known about effective lifelong learning in medicine.

1. Reflective Self Assessment (What improvements can I make?)

Physicians must participate in an ongoing process of reflective self-evaluation, self-assessment and practice assessment, with subsequent successful completion of appropriate educational or improvement activities.

2. Assessment of Knowledge and Skills (What do I need to know and be able to do?)

Physicians must demonstrate the knowledge, skills and abilities necessary to provide safe, effective patient care within the framework of the six general competencies as they apply to their individual practice.

3. Performance in Practice (How am I doing?)

Physicians must demonstrate accountability for performance in their practice using a variety of methods that incorporate reference data to assess their performance in practice and guide improvement.

STATE MEMBER BOARD RESOURCES

Oregon Administrative Rules on Reentry for Physician Assistants (p. 27)

Oregon Administrative Rules on Reentry for Physicians (p. 28)

North Carolina Rule on Reentry to Practice (p. 30)

Nebraska Reentry License (p. 33)

A detailed overview of state board requirements for reentry is also available in the *2012 State Medical Licensure Requirements and Statistics* book published by the American Medical Association. The book includes data such as number and percent of boards that currently have a reentry policy, the average length of time out of practice after which boards require a reentering physician to complete a reentry program, and a table of physician reentry regulations by board.

**OREGON MEDICAL BOARD PROPOSED RULE ON REENTRY FOR PHYSICIAN ASSISTANTS
CHAPTER 847, DIVISION 050 – OREGON MEDICAL BOARD**

PROPOSED RULES CHANGES - FIRST REVIEW – JULY 2011

Proposed rule amendment establishes requirements for re-entry to practice after ceasing practice for more than one year and contains general language and grammar housekeeping.

847-050-0043

Inactive Registration and Re-Entry to Practice

(1) Any physician assistant licensed in this state who changes location to some other state or country, or who is not in a current supervisory relationship with a licensed physician for 6 months or more, will be listed by the Board as inactive.

(2) If the physician assistant wishes to resume active status to practice in Oregon, the physician assistant must submit the Affidavit of Reactivation and processing fee, satisfactorily complete the reactivation process and be approved by the Board before beginning active practice in Oregon.

(3) The Board may deny active registration if it judges the conduct of the physician assistant during the period of inactive registration to be such that the physician assistant would have been denied a license if applying for an initial license

(4) If a physician assistant applicant has ceased practice for a period of 12 or more consecutive months immediately preceding the application for licensure or reactivation, the applicant may be required to do one or more of the following:

(a) Obtain certification or re-certification by the National Commission on the Certification of Physician Assistants (N.C.C.P.A.);

(b) Provide documentation of current N.C.C.P.A. certification;

(c) Complete 30 hours of Category I continuing medical education acceptable to the Board for every year the applicant has ceased practice;

(d) Agree to increased chart reviews upon re-entry to practice.

(5) The physician assistant applicant who has ceased practice for a period of 24 or more consecutive months may be required to complete a re-entry plan to the satisfaction of the Board. The Board must review and approve a re-entry plan prior to the applicant beginning the re-entry plan. Depending on the amount of time out of practice, the re-entry plan may contain one or more of the requirements listed in section (4) of this rule and such additional requirements as determined by the Board.

Stat. Auth.: ORS 677.265

Stats. Implemented: ORS 677.512

**OREGON PROPOSED ADMINISTRATIVE RULES FOR PHYSICIANS
CHAPTER 847, DIVISION 020 – OREGON MEDICAL BOARD**

FIRST REVIEW RULE ADOPTION – OCTOBER 2011

The amendment includes the new Osteopathic school opening in Oregon and clarifies the standards for re-entry to practice.

847-020-0183

Re-Entry to Practice – SPEX or COMVEX Examination, Re-Entry Plan and Personal Interview

If an applicant has ceased the practice of medicine for a period of 12 or more consecutive months immediately preceding the application for licensure or reactivation, the applicant may be required to demonstrate clinical competency.

(1) The applicant who has ceased the practice of medicine for a period of 12 or more consecutive months may be required to pass the Special Purpose Examination (SPEX) or Comprehensive Osteopathic Medical Variable-Purpose Examination (COMVEX). This requirement may be waived if the applicant has done one or more of the following:

(a) The applicant has received a current appointment as Professor or Associate Professor at the Oregon Health and Science University or the Western University of Health Sciences College of Osteopathic Medicine of the Pacific; or

(b) The applicant has within ten years of filing an application with the Board:

(A) Completed one year of an accredited residency, or an accredited or Board-approved clinical fellowship; or

(B) Been certified or recertified by a specialty board recognized by the American Board of Medical Specialties or the American Osteopathic Association; or

(c) The applicant has subsequently:

(A) Completed one year of an accredited residency, or

(B) Completed one year of an accredited or Board-approved clinical fellowship, or

(C) Been certified or recertified by a specialty board recognized by the American Board of Medical Specialties or the American Osteopathic Association, or

(D) Obtained continuing medical education to the Board's satisfaction.

(2) The applicant who has ceased the practice of medicine for a period of 24 or more consecutive months may be required to complete a re-entry plan to the satisfaction of the Board. The Board must

review and approve a re-entry plan prior to the applicant beginning the re-entry plan. Depending on the amount of time out-of-practice, the applicant may be required to do one or more of the following:

(a) Pass the SPEX/COMVEX examination;

(b) Practice for a specified period of time under a mentor/supervising physician who will provide periodic reports to the Board;

(c) Obtain certification or re-certification by a specialty board recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association's Bureau of Osteopathic Specialists (AOA-BOS);

(d) Complete a re-entry program as determined appropriate by the Board;

(e) Complete one year of accredited postgraduate or clinical fellowship training, which must be pre-approved by the Board's Medical Director;

(f) Complete at least 50 hours of Board-approved continuing medical education each year for the past three years.

(3) The applicant who fails the SPEX or COMVEX examination three times, whether in Oregon or other states, must successfully complete one year of an accredited residency or an accredited or Board-approved clinical fellowship before retaking the SPEX or COMVEX examination.

(4) The Limited License, SPEX/COMVEX may be granted for a period of up to 6 months. It permits the licensee to practice medicine only until the grade results of the SPEX or COMVEX examination are available and the applicant completes the initial registration process. If the applicant fails the SPEX or COMVEX examination, the Limited License SPEX/COMVEX becomes invalid, and the applicant must cease practice in this state as expeditiously as possible, but not to exceed two weeks after the applicant receives notice of failure of the examination.

(5) The applicant may be required to appear before the Board for a personal interview regarding information received during the processing of the application. The interview must be conducted during a regular meeting of the Board.

(6) All of the rules, regulations and statutory requirements pertaining to the medical school graduate remain in full effect.

Stat. Auth.: ORS 677.175, 677.265

Stats. Implemented: ORS 677.010, 677.175, 677.265

NORTH CAROLINA REENTRY RULE

21 NCAC 32B .1370 REENTRY TO ACTIVE PRACTICE

(a) A physician or physician assistant applicant ("applicant" or "licensee") who has not actively practiced or who has not maintained continued competency, as determined by the Board, for the two-year period immediately preceding the filing of an application for a license from the Board shall complete a reentry agreement as a condition of licensure.

(b) The applicant shall identify a mentoring physician.

(c) The applicant shall propose a reentry plan containing the components outlined in Paragraphs (g) and (h) of this Rule to the Board. The Board shall review the proposed reentry plan and interview the applicant.

(d) Factors that may affect the length and scope of the reentry plan include:

- (1) The applicant's amount of time out of practice;
- (2) The applicant's prior intensity of practice;
- (3) The reason for the interruption in practice;
- (4) The applicant's activities during the interruption in practice, including the amount of practice-relevant continuing medical education;
- (5) The applicant's previous and intended area(s) of practice;
- (6) The skills required of the intended area(s) of practice;
- (7) The amount of change in the intended area(s) of practice over the time the applicant has been out of continuous practice;
- (8) The applicant's number of years of graduate medical education;
- (9) The number of years since completion of graduate medical education; and
- (10) As applicable, the date of the most recent ABMS, AOA or equivalent specialty board, or National Commission on Certification of Physician Assistant certification or recertification.

(e) If the Board approves an applicant's reentry plan, it shall be incorporated by reference into a reentry agreement and executed by the applicant, the Board and the mentoring physician.

(f) After the reentry agreement has been executed, and the applicant has completed all other requirements for licensure, the applicant shall receive a restricted License. The licensee may not practice outside of the scope of the reentry agreement and its referenced reentry plan during the reentry period.

(g) The first component of a reentry plan is an assessment of the applicant's current strengths and weaknesses in his or her intended area of practice. The process used to perform the assessment shall be described by the applicant and confirmed by the mentoring physician. The process may include self-reflection, self-assessment, and testing and evaluation by colleagues, educators or others. The applicant and mentoring physician shall evaluate and describe applicant's strengths and areas of needed improvement in regard to the core competencies. The assessment shall continue throughout the reentry period as the licensee and the mentoring physician practice together.

(h) The second component of the reentry plan is education. Education shall address the licensee's areas of needed improvement. Education shall consist of:

- (1) a reentry period of retraining and education under the guidance of a mentoring physician, upon terms as the Board may decide, or
- (2) a reentry period of retraining and education under the guidance of a mentoring physician consisting of the following:
 - (A) Phase I – The observation phase. During the observation phase, the licensee will not practice, but will observe the mentoring physician in practice.
 - (B) Phase II – Direct supervision phase. During the direct supervision phase, the licensee shall practice under the direct supervision of the mentoring physician. Guided by the core competencies, the mentoring physician shall reassess the licensee's progress in addressing identified areas of needed improvement.
 - (C) Phase III – Indirect supervision phase. During the indirect supervision phase, the licensee shall continue to practice with supervision of the mentoring physician. Guided by the core competencies, and using review of patient charts and regular meetings, the mentoring physician shall reassess the licensee's progress in addressing the areas of needed improvement.
 - (D) No later than 30 days after the end of phase I and II, the mentoring physician shall send a report to the Board regarding the licensee's level of achievement in each of the core competencies. At the completion of phase III the mentoring physician shall submit a summary report to the Board regarding the licensee's level of achievement in each of the core competencies and affirm the licensee's suitability to resume practice as a physician or to resume practice as a physician assistant.
 - (E) If the mentoring physician reassesses the licensee and concludes that the licensee requires an extended reentry period or if additional areas of needed improvement are identified during Phases II or III, the Board, the licensee and the mentoring physician shall amend the reentry agreement.

(i) Under the terms of either reentry periods Subparagraph (h)(1) or (h)(2) of this Rule, the mentoring physician may terminate his role as the mentoring physician upon written notice to the Board. Such written notice shall state the reasons for termination. The licensee's approval is not required for the mentoring physician to terminate his role as mentoring physician. Upon receipt of the notice of termination, the Board shall place the licensee's license on inactive status. Within six months from the effective date of the mentoring physician's termination, the licensee shall provide a substitute mentoring physician, who must be approved by the Board in writing, and resume the reentry plan upon such terms as are acceptable to the Board. In such event, an amended reentry agreement must be executed prior to resumption of the reentry plan. If licensee does not resume the reentry plan as required herein within six months from the effective date of the mentoring physician's termination, then the Board shall not return the licensee to active status unless and until licensee applies and is approved for reactivation of the license with a new reentry agreement and reentry plan, which must be in place before licensee may resume practice as a physician or physician assistant.

(j) Under the terms of either reentry periods Subparagraph (h)(1) or (h)(2) of this Rule, the licensee may terminate the relationship with the mentoring physician upon written notice to the Board. Such written notice shall state the reasons for termination. The mentoring physician's approval is not required for the licensee to terminate this relationship. Upon receipt of the notice of termination, the Board shall place the licensee's license on inactive status. Within six months from the effective date of the mentoring physician's termination, the licensee shall provide a substitute mentoring physician, who must be approved by the Board in writing, and resume the reentry plan upon such terms as are

acceptable to the Board. In such event, an amended reentry agreement must be executed prior to resumption of the reentry plan. If licensee does not resume the reentry plan as required herein within six months from the effective date of the mentoring physician's termination, then the Board shall not return the licensee to active status unless and until licensee applies and is approved for reactivation of the license with a new reentry agreement and reentry plan, which must be in place before licensee may resume practice as a physician or physician assistant.

(k) The licensee shall meet with members of the Board at such dates, times and places as directed by the Board to discuss the licensee's transition back into practice and any other practice-related matters.

(l) Unsatisfactory completion of the reentry plan or practicing outside the scope of the reentry agreement, as determined by the Board, shall result in the automatic inactivation of the licensee's license, unless the licensee requests a hearing within 30 days of receiving notice from the Board.

(m) If the Board determines the licensee has successfully completed the reentry plan, the Board shall terminate the reentry agreement and notify the licensee that the license is no longer restricted.

*History Note: Authority G.S. 90-8.1; 90-14(a)(11a);
Eff. March 1, 2011.*

NEBRASKA REENTRY LICENSE

TITLE: Provide for reentry licenses under the Medicine and Surgery Practice Act

05/12/2011 PASSED ON FINAL READING 46-0-3.

05/12/2011 PRESIDENT/SPEAKER SIGNED.

05/12/2011 PRESENTED TO GOVERNOR ON MAY 12, 2011.

(1)(a) Present proof that he or she is a graduate of an accredited school or college of medicine, (b) if a foreign medical graduate, provide a copy of a permanent certificate issued by the Educational Commission on Foreign Medical Graduates that is currently effective and relates to such applicant or provide such credentials as are necessary to certify that such foreign medical graduate has successfully passed the Visa Qualifying Examination or its successor or equivalent examination required by the United States Department of Health and Human Services and the United States Citizenship and Immigration Services, or (c) if a graduate of a foreign medical school who has successfully completed a program of American medical training designated as the Fifth Pathway and who additionally has successfully passed the Educational Commission on Foreign Medical Graduates examination but has not yet received the permanent certificate attesting to the same, provide such credentials as certify the same to the Division of Public Health of the Department of Health and Human Services;

(2) Present proof that he or she has served at least one year of graduate medical education approved by the board or, if a foreign medical graduate, present proof that he or she has served at least three years of graduate medical education approved by the board;

(3) Pass a licensing examination approved by the board covering appropriate medical subjects; and

(4) Present proof satisfactory to the department that he or she, within the three years immediately preceding the application for licensure, (a) has been in the active practice of the profession of medicine and surgery in some other state, a territory, the District of Columbia, or Canada for a period of one year, (b) has had at least one year of graduate medical education as described in subdivision (2) of this section, (c) has completed continuing education in medicine and surgery approved by the board, (d) has completed a refresher course in medicine and surgery approved by the board, or (e) has completed the special purposes examination approved by the board.

Sec. 3. (1) The department, with the recommendation of the board, may issue a reentry license to a physician who has not actively practiced medicine for the two-year period immediately preceding the filing of an application for a reentry license or who has not otherwise maintained continued competency during such period as determined by the board.

(2) To qualify for a reentry license, the physician shall meet the same requirements for licensure as a regular licensee and submit to evaluations, assessments, and an educational program as required by the board.

(3) If the board conducts an assessment and determines that the applicant requires a period of supervised practice, the department, with the recommendation of the board, may issue a reentry license allowing the applicant to practice medicine under supervision as specified by the board. After satisfactory completion of the period of supervised practice as determined by the board, the reentry licensee may apply to the department to convert the reentry license to a license issued under section 38-2026.

(4) After an assessment and the completion of any educational program that has been prescribed, if the board determines that the applicant is competent and qualified to practice medicine without supervision, the department, with the recommendation of the board, may convert the reentry license to a license issued under section 38-2026.

(5) A reentry license shall be valid for one year and may be renewed for up to two additional years if approved by the department, with the recommendation of the board.

(6) The issuance of a reentry license shall not constitute a disciplinary action.

ADDITIONAL LITERATURE ON REENTRY

The following peer-reviewed articles provide a more in-depth overview and analysis of the issues associated with reentry.

Bower, EA, English C, Choi D, Cedfeldt AS, Girard DE. Education to return nonpracticing physicians to clinical activity: A case study in physician reentry. *Journal of Continuing Education in the Health Professions*. 2010;30(2):89-94.

Freed GL, Dunham KM, Abraham L. Protecting the public: State medical board licensure policies for active and inactive physicians. *Pediatrics*. 2009;123:643-652.

Kenagy GP, Schneidman BS, Barzansky B, Dalton C, Sirio CA, Skochelak SE. (2011). Physician reentry into clinical practice: Regulatory challenges. *Journal of Medical Regulation*. 2011;97(1):10-15.

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Law MT, Hansen ZK. Medical licensing board characteristics and physician discipline: An empirical analysis. *Journal of Health Politics, Policy and Law*. 2010;35(1):63-93.

ENDNOTES

- ¹ Bush F. Physician reentry to practice: A longstanding challenge with new relevance. *Journal of Medical Regulation*. 2010;96(1):4-5.
- ² Federation of State Medical Boards. *FSMB Report Provides Roadmap for Maintenance of Licensure*. *Fsmb.org*. Press Release, April 28, 2010. Available at: <http://www.fsmb.org/pdf/mol-nr-042610.pdf>. Accessed September 4, 2011.
- ³ Grace ES, Korinek EJ, Weitzel LB, Wentz DK. Physicians reentering clinical practice: Characteristics and clinical abilities. *Journal of Continuing Education in the Health Professions*. 2011; 31(1):49-55.
- ⁴ Mulvey HJ, Jewett EA, Merline A, Towey KJ. Pediatricians over 50 reentering clinical practice: Implications for physicians and the regulatory community. *Journal of Medical Regulation*. 2010;96(2):7-12.
- ⁵ Mark S, Gupta J. Reentry into clinical practice: Challenges and strategies. *JAMA*. 2002;288:1091-1096.
- ⁶ Choudhry NK, Fletcher RH, Soumerai SB. Systematic review: The relationship between clinical experience and quality of health care. *Annals of Internal Medicine*. 2005;142(4):260-273.
- ⁷ Federation of State Medical Boards. *FSMB | Maintenance of Licensure*. Available at: <http://www.fsmb.org/mol.html>. Accessed January 21, 2011.
- ⁸ Chaudhry HJ, Rhyne J, Cain FE, Young A, Crane M, Bush F. Maintenance of licensure: Protecting the public, promoting quality health care. *Journal of Medical Regulation*. 2010; 96(2):13-20.
- ⁹ Bush F. Physician reentry to practice. *Journal of Medical Regulation*. 4-5.
- ¹⁰ Mulvey HJ, et al. Pediatricians over 50 reentering clinical practice. *Journal of Medical Regulation*. 7-12.
- ¹¹ The Physician Reentry into the Workforce Project. *The Physician Reentry into the Workforce Project - Home*. Available at: <http://www.physicianreentry.org/>. Accessed January 20, 2011.
- ¹² American Medical Association. *Physician Re-entry – Home*. Available at: www.ama-assn.org/ama/pub/education-careers/finding-position/physician-reentry.shtml. Access January 20, 2011.
- ¹³ Freed GL, Abraham LM, Brzoznowski KF. Inactive physicians: The state of our understanding. *The Journal of Pediatrics*. 2007;151(4):431-434.
- ¹⁴ Federation of State Medical Boards. Report of the Ad Hoc Committee in Physician Impairment. April 1995. Available at: http://www.fsmb.org/pdf/1995_grpol_Physician_Impairment.pdf.
- ¹⁵ The Physician Reentry into the Workforce Project. A physician reentry into the workforce inventory. Available at: http://www.physicianreentry.org/yahoo_site_admin/assets/docs/Inventory_Checklist_Web_Version.10125922.pdf.

¹⁷ Jewett EA, Brotherton SE, Ruch-Ross H. A national survey of 'inactive' physicians in the United States of America: Enticements to reentry. *Human Resources for Health*. 2011;9:7. Print.

¹⁸ American Medical Association. *State Medical Licensure Requirements and Statistics 2011*. Chicago, IL: American Medical Association, 2010.

¹⁹ Federation of State Medical Boards. *FSMB | Maintenance of Licensure*.

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From: [Ryan, Thomas - DSPS](#)
To: [Agne, Daniel - DSPS](#)
Subject: FW: Fond du Lac County Medical Society meeting
Date: Friday, January 31, 2014 8:50:19 AM

Dan, please add this to the MEB agenda for the Board to consider Tim's speaking to this group. Thanks.

-----Original Message-----

From: Peter Timmermans [REDACTED]
Sent: Thursday, January 30, 2014 8:27 PM
To: Ryan, Thomas - DSPS
Subject: Fond du Lac County Medical Society meeting

I am requesting Dr. Tim Swan to speak to our society meeting on Feb. 27 at South Hills country club in Fond du Lac . We are interested in hearing about the final version of MED 10 and the ramifications for our profession. The members may want to ask some questions as well concerning thoughts about things like future certification of Medical Licensure and maintenance of licensure and possibly a few other related topics. Cocktail hour is at 6:30 pm (with 2 drinks provided per person) and dinner is at 7 pm all of which will be provided to the speaker. The meeting is as long or as short as the speaker wishes but we generally like to finish up by 8:30 pm. As I understand it Tim is vice chairman of the State Medical Examining Board- if not please correct me.

Thank you for your consideration

Peter Timmermans MD
President of Fond du Lac County Medical Society

Sent from my iPad

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