



## STATE OF WISCONSIN

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

Mail to:  
PO Box 8935  
Madison WI 53708-8935

Email: [dsps@wisconsin.gov](mailto:dsps@wisconsin.gov)  
Web: <http://dsps.wi.gov>  
Phone: 608-266-2112

**Governor Scott Walker      Secretary Dave Ross**

---

**MEDICAL EXAMINING BOARD**  
**Room 121A, 1400 East Washington Avenue, Madison**  
**Contact: Tom Ryan (608) 266-2112**  
**November 20, 2013**

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

### AGENDA

**8:00 A.M.**

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

- A. Adoption of Agenda (1-6)**
- B. Approval of Minutes of October 16, 2013 (7-12)**
- C. Administrative Updates**
  - 1. **DLSC Paperless Screening Panel Initiative – APPEARANCE** – Cortney Keo, Matt Niehaus, Janie Brischke and Kelley Foster **(13-16)**
  - 2. Introduction of New Board Appointee – Michael Phillips, M.D.
- D. Speaking Engagements - Discussion and Consideration**
  - 1. Wisconsin Medical Society's Doctor Day in Madison, Wisconsin – Presentation as the Chair of the Medical Examining Board – February 12, 2014 – Ken Simons **(17-18)**
  - 2. Reports from Speaking Engagements
- E. SMART Committee Report – Discussion (19-20)**
- F. Social Media and its Impact on Health Care Delivery – Discussion (21-22)**
- G. FSMB Matters – Discussion and Consideration**
  - 1. FSMB's 102<sup>nd</sup> Annual Meeting – April 24-26, 2014 in Denver, Colorado **(23-28)**
  - 2. Minimum Data Set Pilot Implementation Project **(29-54)**
  - 3. FSMB Call for Nominations **(55-64)**
- H. Fall Newsletter – Discussion**

**I. Legislative Matters**

1. Assembly Bill 139 – Board Review **(79-86)**

**J. Administrative Rule Matters – Discussion and Consideration**

1. **Public Hearing – 9:00 A.M.** – CHR 13-090, SPS 165 Diploma Copies **(65-70)**
2. Clearinghouse Report Review of Med 1.02 CR 13-090 **(71-74)**
3. Legislative Report for Med 1.02 **(75-78)**

**K. Education and Examination Matters – Discussion**

1. 2013 USMLE Annual Report to Medical Licensing Authorities **(87-138)**

**L. Screening Panel Report**

**M. Items Added After Preparation of Agenda:**

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

**N. Public Comments**

**O. Consider Motion to Invite Michael Phillips, MD, into Closed Session**

**CONVENE TO CLOSED SESSION to deliberate on cases following hearing (Wis. Stat. s. 19.85 (1)(a)); to consider licensure or certification of individuals (Wis. Stat. s. 19.85 (1)(b)); to consider closing disciplinary investigation with administrative warning (Wis. Stat. ss. 19.85 (a)(b) and 448.03(8)); to consider individual histories or disciplinary data (Wis. Stat. s. 19.85 (1)(f)); and, to confer with legal counsel (Wis. Stat. s. 19.85)**

- P. Presentation and Deliberation of Proposed Decisions and Orders**
1. **10:00 A.M. APPEARANCE** – Kim Kluck, DLSC Attorney, Peri L. Aldrich, M.D., and Steven Sager, Attorney – Peri L. Aldrich, M.D. – DHA Case Number SPS 12-0031 – DLSC Case Number 11 MED 123 **(139-172)**
  2. Dashir A. Sheikh, M.D. – DHA Case Number SPS 12 – 0010 – DLSC Case Number 10 MED 201 **(173-266)**
  3. Michael N. Mangold, M.D. – DHA Case Number SPS 13-0027 – DLSC Case number 12 MED 235 **(267-278)**
- Q. Presentation and Deliberation of Application Matters**
1. Seeking Equivalency for the 12 Months of ACGME Approved Post-Graduate Training Based on Education and Training – Osayande S. Izeiyamu, M.D. **(279-364)**
- R. Continued Deliberation of Full Board Oral Exam**
1. Kaukab P. Shah, M.D. **(365-412)**
- S. Monitoring Matters – Discussion and Consideration**
1. Jonathan W. Thomas, M.D. – Requesting Reduction in Drug and Alcohol Screens **(413-436)**
- T. Deliberation of Administrative Warnings**
1. 13 MED 037 (M.A.B.) **(437-438)**
  2. 13 MED 040 (T.F.O.) **(439-440)**
- U. Presentation and Deliberation of Proposed Stipulations, Final Decisions and Orders**
1. 09 MED 223, 11 MED 354, 11 MED 376 and 13 MED 146 – Cully R. White, D.O. **(441-450)**
  2. 12 MED 108 – Carla Johnson, D.O. **(451-456)**
  3. 12 MED 356 – Thomas M. Naughton, M.D. **(457-464)**
  4. 13 MED 070 – Craig D. Maskil, M.D. **(465-480)**
  5. 13 MED 082 – Donald F. Stonefeld, M.D. **(481-490)**
- V. Deliberation of Complaint for Determination of Probable Cause in Case Number 11 MED 113 – Kimberly Hammes Frank, M.D. (491-494)**
- W. Deliberation of Petition for Mental Examination in Case Number 11 MED 315 – Guiditta Angelini, M.D. (495-510)**
- X. Case Status Report (511-524)**

**Y. Case Closings**

1. 12 MED 226 (K.C.) **(525-530)**
2. 12 MED 402 (L.W.) **(531-534)**
3. 13 MED 051 (T.S.P.) **(535-544)**
4. 13 MED 105 (M.T.H.) **(545-554)**
5. 13 MED 150 (D.B. & R.A.N.) **(555-560)**
6. 13 MED 189 (B.J.B.) **(561-566)**
7. 13 MED 210 (J.O.) **(567-570)**
8. 13 MED 236 (C.A.) **(571-574)**
9. 13 MED 268 (H.I.G.) **(575-578)**
10. 13 MED 297 (C.L.) **(579-582)**
11. 13 MED 300 (S.K.S.) **(583-586)**

**Z. Consulting with Legal Counsel**

**AA. Deliberation of Items Added After Preparation of the Agenda**

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

**BB. Ratifying Examination Results, Licenses, and Certificates**

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

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

**DD.** Open Session Items Noticed Above not Completed in the Initial Open Session

**ADJOURNMENT**

**CONVENE TO LICENSING COMMITTEE MEETING IMMEDIATELY FOLLOWING  
FULL BOARD MEETING**

**12:00 P.M.**

**ATTENDEES:** Kenneth Simons, Gene Musser, Timothy Swan, Timothy Westlake

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

**12:45 P.M.**

**CLOSED SESSION** – Reviewing applications and conducting oral examinations of ten (10) candidates for licensure – Drs. Capodice, Erickson, Yale, and Vasudevan

Page intentionally left blank

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

**PRESENT:** Greg Collins; Carolyn Ogland, MD; Timothy Westlake, MD; Timothy Swan, MD; Mary Jo Capodice, DO; Jude Genereaux; Rodney Erickson, MD; Suresh Misra, MD; Russell Yale, MD; Gene Musser, MD; and Sridhar Vasudevan, MD  
**EXCUSED:** James Barr; Kenneth Simons, MD  
**STAFF:** Tom Ryan, Executive Director; Joshua Archiquette, Bureau Assistant; Matthew Guidry, Bureau Assistant; and other Department staff

**CALL TO ORDER**

Timothy Swan, Vice Chair, called the meeting to order at 8:00 a.m. A quorum of eleven (11) was confirmed.

**ADOPTION OF AGENDA**

**MOTION:** Suresh Misra moved, seconded by Mary Jo Capodice, to adopt the agenda as published. Motion carried unanimously.

**APPROVAL OF MINUTES**

- **Add: “HAS THE WISCONSIN MEDICAL EXAMINING BOARD ADOPTED SPECIFIC GUIDELINES FOR PHYSICIANS WHO ARE TREATING CHRONIC PAIN OR PRESCRIBING CONTROLLED SUBSTANCES FOR THE TREATMENT OF PAIN?” To the position statement motion regarding treatment of pain in the minutes from September 18, 2013**

**MOTION:** Sridhar Vasudevan moved, seconded by Suresh Misra, to approve the minutes of September 18, 2013 as amended. Motion carried unanimously.

**SPEAKING ENGAGEMENTS**

**MOTION:** Sridhar Vasudevan moved, seconded by Mary Jo Capodice, to designate Kenneth Simons, MD, as the Board’s representative to speak at the Medical College of Wisconsin Department of Otolaryngology on Thursday, December 5, 2013. Motion carried unanimously.

**LEGISLATIVE AND ADMINISTRATIVE RULE MATTERS**

**MOTION:** Sridhar Vasudevan moved, seconded by Greg Collins, to approve the Scope Statement on Continuing Education Audit 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. Motion carried unanimously.

**FALL NEWSLETTER**

**MOTION:** Timothy Westlake moved, seconded by Suresh Misra, to approve the Fall Newsletter content and designate Tim Swan as the Board's representative to work with DSPS staff on any additional edits and authorize Dr. Swan to give final approval. Motion carried unanimously.

### **MOTIONS**

**MOTION:** Gene Musser moved, seconded by Suresh Misra, to delegate to the Chair, or the Vice Chair if the Chair is unavailable, and two board members selected to consider a petition for summary suspension pursuant to Wis. Stat. sec. 448.03(4), the authority to also make a determination of probable cause, if appropriate, on behalf of the Board with regard to any formal complaint and notice of hearing submitted in conjunction with the petition.. Motion carried unanimously.

### **SCREENING PANEL REPORT**

Jude Genereaux reported that twenty-one (21) cases were opened. two (2) ten-day letters were sent.

### **CLOSED SESSION**

**MOTION:** Sridhar Vasudevan moved seconded by Carolyn Ogland, 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.). Timothy Swan, Vice Chair; read the language of the motion. The vote of each member was ascertained by voice vote. Roll Call Vote: Timothy Swan – yes; Greg Collins – yes; Timothy Westlake – yes; Mary Jo Capodice – yes; Rodney Erickson – yes; Russell Yale – yes; Sridhar Vasudevan – yes; Gene Musser – yes; Suresh Misra – yes; Carolyn Ogland, - yes; and Jude Genereaux – yes. Motion carried unanimously.

The Board convened into Closed Session at 9:22 a.m.

### **FULL BOARD ORAL EXAM OF CANDIDATES FOR LICENSURE**

**MOTION:** Suresh Misra moved, seconded by Gene Musser to find that Jamey L. Walker, M.D. passed her full Board Examination. Motion carried unanimously.

**MOTION:** Carolyn Ogland moved, seconded by Suresh Misra, to approve Jamey L Walker, M.D.'s application for Medical licensure once all requirements are met. Motion carried unanimously.

**MOTION:** Gene Musser moved, seconded by Jude Genereaux, to defer Kaukab P. Shah, M.D.'s application for Medical licensure pending additional information. Motion carried unanimously.

**MOTION:** Timothy Westlake moved, seconded by Greg Collins to find that Ravi K. Pasupuleti, M.D failed his full Board Examination. Motion carried unanimously

**MOTION:** Russell Yale moved, seconded by Suresh Misra, to deny Ravi K. Pasupuleti, M.D.'s application for Medical licensure. Reason for Denial: Failed his oral Examination due to lack of evidence of an ability to practice with reasonable skill and safety. The Board based its decision upon his lack of adequate clinical experience for the last five years. Motion carried unanimously.

### **MONITORING MATTERS**

**MOTION:** Suresh Misra moved, seconded by Timothy Westlake, to deny the request of Roger Pellmann, M.D. for rescission of Suspension. **Reason for Denial:** Roger Pellmann, M.D. hasn't presented to the Board evidence sufficient to establish his ability to safely and competently resume the practice of medicine and surgery. Motion carried unanimously.

*Pam Stach, Board Legal counsel; recused herself from deliberation of the above matter*

**MOTION:** Timothy Westlake moved, seconded by Gene Musser, to deny the request of Kirsten Peterson, M.D. for reduction in Drug and Alcohol Screens. **Reason for Denial:** Insufficient time to show compliance. Motion carried.

*Sridhar Vasudevan voted no in the above matter*

**MOTION:** Rodney Erickson moved, seconded by Suresh Misra, to rescind, vacate, and expunge the June 13, 2013 order suspending the license of George Boyum, M.D. to practice medicine and surgery in the State of Wisconsin. Motion carried unanimously.

**MOTION:** Rodney Erickson moved, seconded by Suresh Misra, to Amend Previous Final Decision and Order dated November 14, 2012 to remove the costs in the matter of 12 MED 322, George Boyum, M.D. Motion carried unanimously.

### **REQUESTING RESCISSION OF BOARD MOTION TO DENY APPLICATION FOR MEDICAL LICENSURE – NIPA H. SINH, M.D.**

**MOTION:** Gene Musser moved, seconded by Russell Yale, to deny the request of Nipa H. Sing, M.D. to rescind the Board's denial of application for licensure. The Board has reviewed the additional material submitted. Motion carried.

*Sridhar Vasudevan abstained from voting in the above matter.*

**PETITION FOR AUTHORIZATION TO REQUEST EXTENSION OF TIME IN CASE NUMBER 12 MED 381, GRAIG ADERS, M.D. AND DAVID DRAKE, M.D.**

**MOTION:** Gene Musser moved, seconded by Jude Genereaux, to grant the petition for extension of time in case number 12 MED 381, Graig Aders, M.D. and David Drake, M.D. Motion carried unanimously.

**ADMINISTRATIVE WARNINGS**

**MOTION:** Suresh Misra moved, seconded by Greg Collins, to issue an administrative warning in the matter of case number 12 MED 219 (R.L.E.). Motion carried unanimously.

**MOTION:** Jude Genereaux moved, seconded by Timothy Westlake, to close case 12 MED 079 (J.A.M.) for P2 (Prosecutorial Discretion). Motion carried unanimously.

**PROPOSED STIPULATIONS, FINAL DECISIONS AND ORDERS**

**MOTION:** Suresh Misra moved, seconded by Timothy Westlake, to adopt the Findings of Fact, Conclusions of Law, Order and Stipulation in the matter of disciplinary proceedings against Bruce A. Kraus, M.D. (12 MED 375). Motion carried unanimously.

**MOTION:** Greg Collins moved, seconded by Mary Jo Capodice, to adopt the Findings of Fact, Conclusions of Law, Order and Stipulation in the matter of disciplinary proceedings against Paul Strapon III, M.D. (12 MED 440). Motion carried unanimously.

**MOTION:** Suresh Misra moved, seconded by Gene Musser, to adopt the Findings of Fact, Conclusions of Law, Order and Stipulation in the matter of disciplinary proceedings against Arvind Ahuja, M.D. (13 MED 133). Motion carried unanimously.

*Mary Jo Capodice and Russell Yale recused themselves for deliberating and voting on the above matter*

**MOTION:** Sridhar Vasudevan moved, seconded by Gene Musser, to adopt the Findings of Fact, Conclusions of Law, Order and Stipulation in the matter

of disciplinary proceedings against George Darrel Soncrant, D.O. (13 MED 277). Motion carried unanimously.

### **DLSC MATTERS**

#### **Case Closures**

**MOTION:** Suresh Misra moved, seconded by Timothy Westlake, to close case 11 MED 281 (H.M.T.) for P1 (Prosecutorial Discretion). Motion carried unanimously.

#### **RATIFY ALL LICENSES AND CERTIFICATES**

**MOTION:** Sridhar Vasudevan moved, seconded by Jude Genereaux, to delegate ratification of examination results to DSPS staff and to ratify all licenses and certificates as issued. Motion carried unanimously.

#### **RECONVENE TO OPEN SESSION**

**MOTION:** Suresh Misra moved, seconded by Carolyn Ogland, to reconvene into Open Session. Motion carried unanimously.

The Board reconvened into Open Session at 12:42 p.m.

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

**MOTION:** Suresh Misra moved, seconded by Jude Genereaux, to affirm all motions made in closed session. Motion carried unanimously.

#### **ADJOURNMENT**

**MOTION:** Gene Musser moved, seconded by Sridhar Vasudevan, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 12:58 p.m.

Page intentionally left blank

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

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Matthew C. Niehaus, DSPS WebMaster		<b>2) Date When Request Submitted:</b>  11/11/13 Items will be considered late if submitted after 4:30 p.m. on the deadline date: <ul style="list-style-type: none"> <li>▪ 8 business days before the meeting for paperless boards</li> <li>▪ 14 business days before the meeting for all others</li> </ul>	
<b>3) Name of Board, Committee, Council, Sections:</b>  Medical Examining Board			
<b>4) Meeting Date:</b>  11/20/13	<b>5) Attachments:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b>  DLSC Paperless Screening Panel Initiative - APPEARANCE	
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	<b>8) Is an appearance before the Board being scheduled?</b>  <input checked="" type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>	
<b>10) Describe the issue and action that should be addressed:</b>  Jane Brischke: Program & Policy Analyst – Advanced Cortney Keo: Records Management Supervisor Matthew C. Niehaus: DSPS Webmaster Kelley Foster: Medical Examining Board Intake  The above staff will be appearing before the Medical Examining Board to present the DLSC Paperless Screening Panel Initiative. Beginning in December, Medical Examining Board Screening Panel Members will be able to access case materials through the Board SharePoint site.			
<b>11) Authorization</b>			
 Signature of person making this request		11/11/13 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.			

# **BOARD APPEARANCE REQUEST FORM**

## **Appearance Information**

**Board Name:** Medical Examining Board

**Board Meeting Date:** 11/11/13

**Person Submitting Agenda Request:** Matthew C. Niehaus: DSPS WebMaster

### **Persons requesting an appearance:**

Jane Brischke: Program & Policy Analyst – Advanced

Cortney Keo: Records Management Supervisor

Matthew C. Niehaus: DSPS Webmaster

Kelley Foster: Medical Examining Board Intake

### **Reason for Appearance:**

The above DSPS staff are appearing before the Medical Examining Board to present the DLSC Paperless Screening Panel.

Medical Examining Board > Legal Services and Compliance > All Documents >

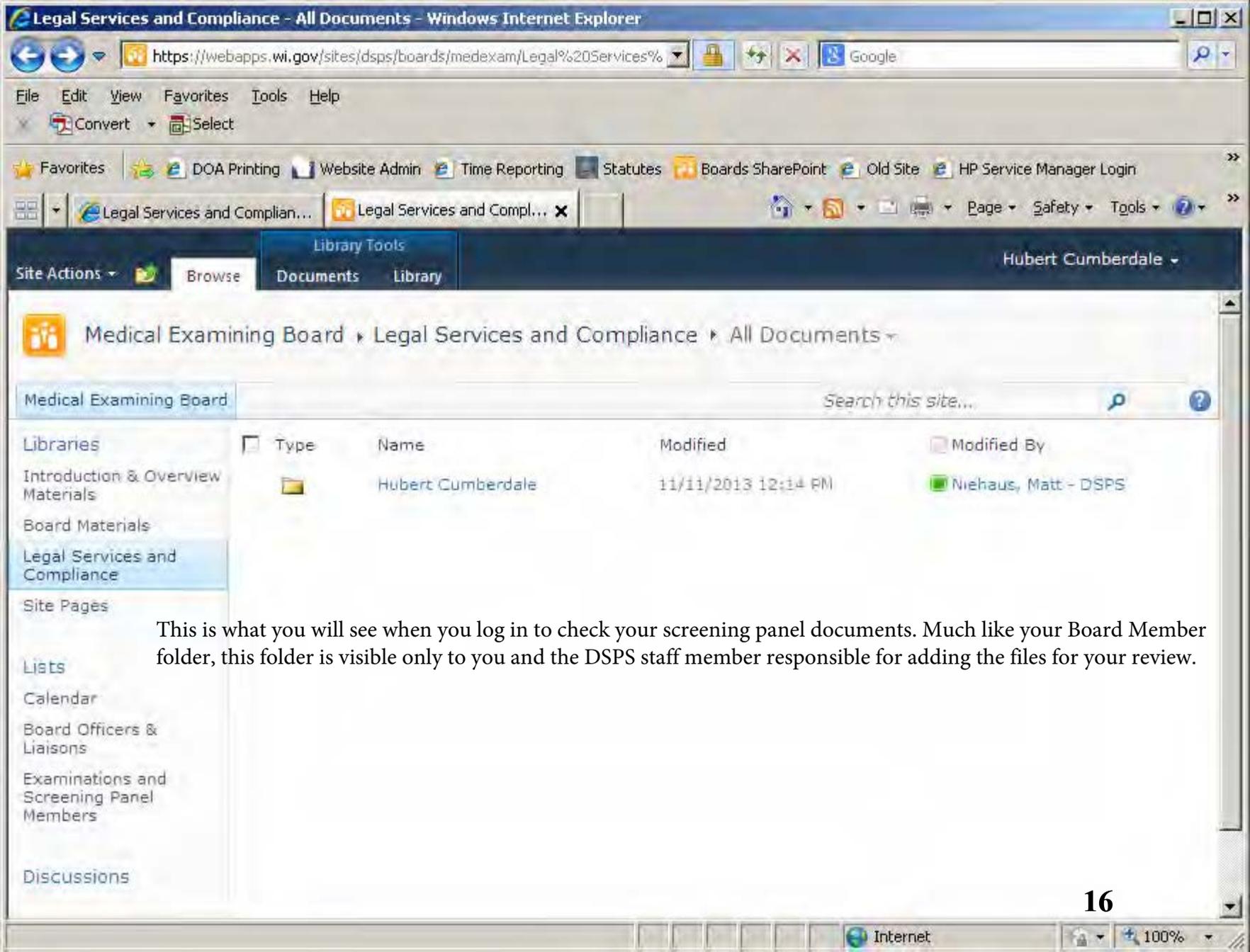
This is what DSPS Intake Staff will see when they upload your screening panel files.

Medical Examining Board

Search this site...

- Libraries
- Introduction & Overview Materials
- Board Materials
- Legal Services and Compliance**
- Credentialing
- Board Member Folders
- Site Pages
- Lists
- Calendar
- Board Officers & Liaisons
- Examinations and Screening Panel Members
- Discussions

<input type="checkbox"/>	Type	Name	Modified	<input type="checkbox"/>	Modified By
<input type="checkbox"/>	Folder	Carolyn Ogland Vukich	9/24/2013 3:00 PM	<input checked="" type="checkbox"/>	Niehaus, Matt - DSPS
<input type="checkbox"/>	Folder	Gene Nusser	9/24/2013 3:00 PM	<input checked="" type="checkbox"/>	Niehaus, Matt - DSPS
<input type="checkbox"/>	Folder	Greg Collins	9/24/2013 3:00 PM	<input checked="" type="checkbox"/>	Niehaus, Matt - DSPS
<input type="checkbox"/>	Folder	Hubert Cumberlanddale	11/11/2013 12:14 PM	<input checked="" type="checkbox"/>	Niehaus, Matt - DSPS
<input type="checkbox"/>	Folder	Jim Barr	9/24/2013 3:00 PM	<input checked="" type="checkbox"/>	Niehaus, Matt - DSPS
<input type="checkbox"/>	Folder	Jude Genereaux	9/24/2013 3:00 PM	<input checked="" type="checkbox"/>	Niehaus, Matt - DSPS
<input type="checkbox"/>	Folder	Kenneth Simons	9/24/2013 3:00 PM	<input checked="" type="checkbox"/>	Niehaus, Matt - DSPS
<input type="checkbox"/>	Folder	Mary Jo Capodice	9/24/2013 3:00 PM	<input checked="" type="checkbox"/>	Niehaus, Matt - DSPS
<input type="checkbox"/>	Folder	Rodney Erickson	9/24/2013 3:01 PM	<input checked="" type="checkbox"/>	Niehaus, Matt - DSPS
<input type="checkbox"/>	Folder	Russell Yale	9/24/2013 3:01 PM	<input checked="" type="checkbox"/>	Niehaus, Matt - DSPS
<input type="checkbox"/>	Folder	Screening Attorney	9/24/2013 3:23 PM	<input checked="" type="checkbox"/>	Niehaus, Matt - DSPS
<input type="checkbox"/>	Folder	Sridhar Vasudevan	9/24/2013 3:01 PM	<input checked="" type="checkbox"/>	Niehaus, Matt - DSPS
<input type="checkbox"/>	Folder	Suresh Misra	9/24/2013 3:01 PM	<input checked="" type="checkbox"/>	Niehaus, Matt - DSPS
<input type="checkbox"/>	Folder	Timothy Swan	9/24/2013 3:01 PM	<input checked="" type="checkbox"/>	Niehaus, Matt - DSPS
<input type="checkbox"/>	Folder	Timothy Westlake	9/24/2013 3:01 PM	<input checked="" type="checkbox"/>	Niehaus, Matt - DSPS



This is what you will see when you log in to check your screening panel documents. Much like your Board Member folder, this folder is visible only to you and the DSPS staff member responsible for adding the files for your review.

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

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:  <b>Joshua Archiquette, Bureau Assistant</b>		2) Date When Request Submitted:  <b>21 Oct 2013</b> <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:  <b>Medical Examining Board</b>			
4) Meeting Date:  <b>20 Nov 2013</b>	5) Attachments: <input type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? <b>Speaking Engagements</b> <ul style="list-style-type: none"> <li>• <b>Doctor Day - February 12, 2014</b></li> </ul>	
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 ( <a href="#">Fill out Board Appearance Request</a> ) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:  <p>Dr. Simons:</p> <p>There are a large number of physician organizations combining to hold a Doctor Day in Madison on February 12, 2014. We would be delighted if you would be a speaker at this meeting. We are expecting a minimum of 150 attendees for the day, and believe the number could be higher.</p> <p>Your presentation would be as the chair of the Medical Examining Board, and would be for 15 minutes – you can decide how much of that you’d like to leave for Q&amp;A, if any. We believe those attending would be thrilled to be able to see “one of their own” address the various issues the MEB faces, including any proactive proposals that may be in the legislative and/or administrative code hopper at that time. Other invitees to this event include Gov. Walker and U.S. Rep. Mark Pocan.</p> <p>We anticipate the time of your talk would be at 9:45 am at a facility near the State Capitol building.</p> <p>Please let me know if you have any questions – would love to have you attend!</p> <p>mg</p> <p>Mark M. Grapentine, JD          Senior VP - Government Relations          Wisconsin Medical Society          330 E. Lakeside Street          Madison, WI 53715          ofc: (608) 442-3768          cell: (608) 575-2514          email: <a href="mailto:Mark.Grapentine@wismed.org">Mark.Grapentine@wismed.org</a>          twitter: @mgraps</p>			

Page intentionally left blank

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

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Joshua Archiquette, Bureau Assistant		<b>2) Date When Request Submitted:</b>  11/5/13 <small>Items will be considered late if submitted after 4:30 p.m. and less than 8 work days before the meeting.</small>	
<b>3) Name of Board, Committee, Council, Sections:</b> Medical Examining Board			
<b>4) Meeting Date:</b>  11/20/2013	<b>5) Attachments:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b> SMART Committee Report	
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	<b>8) Is an appearance before the Board being scheduled?</b>  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>	
<b>10) Describe the issue and action that should be addressed:</b>  The Board will discuss a report on SMART Committee			
<b>11) Authorization</b>			
Signature of person making this request			Date
Supervisor (if required)			Date
Executive Director signature (indicates approval to add post agenda deadline item to agenda)    Date			
<b>Directions for including supporting documents:</b> 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

Page intentionally left blank

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

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Joshua Archiquette, Bureau Assistant		<b>2) Date When Request Submitted:</b>  11/7/13 <small>Items will be considered late if submitted after 4:30 p.m. and less than 8 work days before the meeting.</small>	
<b>3) Name of Board, Committee, Council, Sections:</b> Medical Examining Board			
<b>4) Meeting Date:</b>  11/20/2013	<b>5) Attachments:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b> <b>Social Media and its Impact on Health Care Delivery</b>	
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	<b>8) Is an appearance before the Board being scheduled?</b>  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>	
<b>10) Describe the issue and action that should be addressed:</b>  The Board will discuss an article found on Kevinmd.com <a href="http://www.kevinmd.com/blog/2013/11/google-helpouts-bring-telehealth-masses.html">http://www.kevinmd.com/blog/2013/11/google-helpouts-bring-telehealth-masses.html</a>			
<b>11) Authorization</b>			
Signature of person making this request			Date
Supervisor (if required)			Date
Executive Director signature (indicates approval to add post agenda deadline item to agenda)			Date
<b>Directions for including supporting documents:</b> 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

Page intentionally left blank

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

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:  <b>Joshua Archiquette, Bureau Assistant</b>		2) Date When Request Submitted:  <b>30 Oct 2013</b> <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:  <b>Medical Examining Board</b>			
4) Meeting Date:  <b>20 Nov 2013</b>	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? <b>FSMB Matters</b> - <b>FSMB's 102<sup>nd</sup> Annual Meeting – April 24-26 Denver, Colorado</b>	
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 ( <a href="#">Fill out Board Appearance Request</a> ) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:  <p>Dear Presidents/Chairs and Executive Directors,</p> <p>Attached is information regarding the scholarship program for the FSMB's 102<sup>nd</sup> Annual Meeting which will be in Denver, Colorado. Please complete and return the Scholarship Recipients Form by <b><u>Monday, February 3.</u></b></p> <p>If you have any questions for me, please do not hesitate ask.</p> <p>See you in Denver!!</p> <p>Deanne Dooley Executive Administrative Assistant, Meetings &amp; Travel</p> <p><b>Federation of State Medical Boards</b>          400 Fuller Wiser Road   Suite 300   Euless, TX 76039          817-868-4086 direct   817-868-4183 fax  <a href="mailto:ddooley@fsmb.org">ddooley@fsmb.org</a>   <a href="http://www.fsmb.org">www.fsmb.org</a></p>			
11) <b>Authorization</b>			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)		Date	



October 28, 2013

Dear Colleagues:

Preparations are underway for FSMB's 2014 Annual Meeting scheduled for April 24-26 in Denver, Colorado. The FSMB's House of Delegates (HOD) business meeting is held on the last day of the Annual Meeting. FSMB member board participation at the HOD meeting is extremely important because it is the boards' unique opportunity to gain greater insight into the FSMB's work and to contribute to the organization's policymaking process. The role of the voting delegate in that process is especially important because the delegate represents his/her state medical board on matters of significance to the board and elects FSMB Fellows to assist in carrying out the FSMB's work.

In anticipation of the HOD business meeting, we ask that you consider which of your board members will be best suited to serve as your voting delegate.

In order for the voting delegate to serve in a truly representative capacity, the delegate is asked to fulfill a number of responsibilities.

Before the HOD meeting, the voting delegate is asked to:

- Become familiar with the structure, purpose and history of the FSMB HOD as well as FSMB's policymaking and election processes
- Attend meetings of the state medical board the delegate represents to gain early information on statewide and national issues to be addressed at the HOD meeting
- Review all pre-meeting materials
- **Participate in a Voting Delegate Webinar on March 13, 2014 from 3:00-4:00 pm CDT**
- **Attend the Candidates Forum and Reference Committee meeting at the Annual Meeting and provide Reference Committee testimony as necessary**
- Network with colleagues at the Annual Meeting for additional information and perspectives on issues

During the meeting, the voting delegate is asked to:

- Follow the meeting rules as outlined by the Rules Committee
- Represent the position of the delegate's board during discussions as necessary
- Vote at the time requested

Following the meeting, the voting delegate is asked to:

- Report the results of the HOD meeting to the delegate's board
- Remain current on statewide and national issues affecting medical regulation in preparation for the next HOD meeting

As you can see, the role of the voting delegate should not be taken lightly. We therefore encourage you to give careful consideration in the selection of the individual who will be your representative at our 2014 meeting.

Sincerely,

Jon V. Thomas, MD, MBA  
Chair

Humayun J. Chaudhry, DO, MACP  
President and CEO

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039  
(817) 868-4000 | FAX (817) 868-4098 | WWW.FSMB.ORG

**TRAVEL REIMBURSEMENT GUIDELINES  
FOR VOTING DELEGATES  
ATTENDING THE FSMB ANNUAL MEETING**

The Federation of State Medical Boards of the United States, Inc. (FSMB) will reimburse board presidents/chairs up to \$1,800 for travel, lodging and meal expenses incurred to attend the FSMB's Annual House of Delegates Meeting according to the Travel Reimbursement Guidelines. In the event the president/chair cannot attend the meeting, an alternate member of the medical board may be selected by the board president/chair to attend as the designated voting delegate.

**Only board members or associate members who participate as the voting delegate at the House of Delegates meeting will be eligible for reimbursement of expenses under this policy.**

The Annual Meeting registration fee will be waived.

**AIR TRAVEL**

The FSMB will reimburse the cost of one coach class, round trip airline ticket for the voting delegate attending the annual meeting. **Tickets must be booked 14 days prior to travel through the FSMB's authorized travel agency and billed directly to the corporate account. Tickets booked less than 14 days prior to travel or booked elsewhere will not be reimbursed.**

However, if the voting delegate has access to a lower fare (such as a government rate) through another source, the FSMB will reimburse that airfare provided he/she obtains a written quote from the FSMB's travel agency for comparison. **The FSMB's Director of Meetings & Travel must be notified prior to making these alternate reservations.**

Should the voting delegate choose a flight itinerary at a higher fare than a comparable fare offered by the FSMB's travel agency, he/she will be responsible for the additional expense regardless of whether the \$1,800 expense cap is reached.

**Airline Class of Service**

All air travel must be in coach class. Travelers are expected to use the lowest logical airfare available (see below for definition) regardless of personal participation in a frequent flyer program. **Tickets will be nonrefundable and nontransferable.**

**Upgrades for Domestic Air Travel**

Upgrade coupons may be used only if they do not disqualify the traveler from a cheaper fare and are only allowed at the traveler's personal expense.

**Personal Stopovers**

Travelers must pay for any personal stopovers which increase airfare.

**Baggage Fees**

The FSMB will reimburse airline charges for up to two checked bags. Overweight baggage fees will not be reimbursed.

**Preferred Seating**

If traveler's seating preference is not available within the "base airfare", the FSMB will reimburse up to \$75 roundtrip to purchase such seating.

**Changes to Tickets**

Changes to tickets must be pre-approved by FSMB's Director of Meetings & Travel. Any additional fare or fee resulting from the change (including for standby travel on an earlier flight) will be at the traveler's expense unless the FSMB is requesting the traveler to make the change.

**Lowest Airfare Definition**

Travelers are expected to book the lowest logical airfare as determined by the travel agency based on the following parameters.

Negotiated Airfares - This could include designated airlines for certain routes, with which the Federation has a negotiated rate.

Routing - Routing requires no more than one stop with one change of plane for each way of a round trip. Routing does not increase the one-way total elapsed trip time (origin to destination) by more than 2 hours.

Time Window - Departure/arrival must be no more than 1 ½ hours before or after requested time for flights of 4 or more hours and 1 hour for flights less than 4 hours.

### **GROUND TRANSPORTATION**

If using rail or personal automobile, the total expense for such travel may not exceed the cost of prevailing coach airfare.

Reimbursement for use of personal autos will be at the prevailing IRS standard mileage rate plus fees for parking and tolls. Other auto expenses (violation tickets, maintenance) are not reimbursable.

Reasonable cab fares and transfers to and from the airport will be reimbursed. **Rental car expenses are not reimbursable.**

### **LODGING**

In order to take advantage of the FSMB's scholarship, the Voting Delegate must stay at the host hotel. Hotel costs will be reimbursed at the host hotel's single convention rate for up to **four nights from Wednesday through Saturday nights.**

### **MEALS & INCIDENTALS**

Meals (**when not provided**) and incidentals (e.g., tips, phone calls) will be reimbursed up to \$100 per day from Wednesday through Sunday. Consumption of alcohol is at the traveler's personal risk and the FSMB expects the traveler to act responsibly and avoid intoxication.

**Receipts for all meals are required. Itemized restaurant receipts should be submitted. Credit card signature receipts alone may not meet the requirements of this policy. The FSMB does not reimburse on a per diem basis.**

Excessive phone calls, in terms of number or length, will not be reimbursed.

### **MISCELLANEOUS EXPENSES**

Miscellaneous personal and business expenses are not reimbursable. These include:

- a) expense charges for family members or guests;
- b) expenses incurred for business related to other organizations;
- c) movies, gift shop purchases, dry cleaning/laundry
- d) Continuing Medical Education fees

Any such charges should be deducted when completing your reimbursement form.

### **SPECIAL TRAVEL ACCOMMODATIONS**

Individuals with documented disabilities as defined under the Americans with Disabilities Act Amendments Act of 2008 (ADAAA) may request special travel accommodations. Individuals requesting special accommodations must provide appropriate documentation to support the request. Requests will be evaluated on an individual basis.

The ADAAA and accompanying regulations define a person with a disability as someone with a physical or mental impairment that substantially limits one or more major life activities; or (2) has a record of such an impairment; or (3) is regarded as having such an impairment. The purpose of documentation is to validate that the individual is covered under the ADAAA as a disabled individual. The purpose of accommodations is to provide equal access for individuals traveling on behalf of FSMB.

### **REIMBURSEMENT FORMS**

The FSMB Request for Reimbursement of Travel Expenses should be completed and submitted to the FSMB's Director of Meetings and Travel within **60 days** following completion of travel. Requests for extensions must be in writing. Reimbursement will not be granted for requests received after 60 days unless a request for an extension has been submitted. **Receipts for all individual expenses exceeding \$25 must be attached to the reimbursement request.**

## MEMORANDUM

DATE: October 29, 2013

TO: **Presidents/Chairs and Executive Directors  
Member Medical and Osteopathic Boards**

FROM: Deanne Dooley  
Executive Administrative Assistant  
Meeting and Travel Planning

RE: **Scholarship Program for the  
FSMB 2014 House of Delegates and Annual Meeting**

---

Preparations are underway for FSMB's 102<sup>nd</sup> Annual Meeting to be held April 24 – April 26, 2014, at the Hyatt Regency Denver in Denver, CO.

Reimbursement up to \$1,800 in travel expenses will be provided for each member board's president/chair attending as the voting delegate at the FSMB's House of Delegates Meeting on Saturday, April 26, 2014. If the president/chair is unable to participate, an alternate member of the medical board may be selected by the president/chair to attend as the designated voting delegate. **Please see the attached letter from the FSMB's Chair and President/CEO stressing the importance of the role of the voting delegate.**

The FSMB will also reimburse the executive director of each member board up to \$1,800 for expenses incurred in relation to his/her attendance at the Annual Meeting. In the event the executive director cannot participate, the president/chair may select another senior staff person to attend in the executive director's place.

Reimbursement for the voting delegate and the executive director will be made in accordance with the attached guidelines. Please complete the attached Scholarship Response Form identifying your board's scholarship recipients. **The deadline for returning the response form is February 3, 2014.** Upon receipt of the form, scholarship information and travel policies will be sent to the recipients.

**Annual membership dues for member boards must be paid in full in order for both the voting delegate and the executive director to take advantage of the scholarship opportunity.** A draft agenda for the 2014 Annual Meeting is posted on the FSMB's website at [www.fsmb.org](http://www.fsmb.org). Should you have any questions, you may reach me at 817-868-4086.



November 6, 2013

Dear Colleagues,

I am pleased to announce that the FSMB will award ten (10) scholarships for public members to attend the 2014 Annual Meeting. The scholarships will be in the amount of \$1,800 each.

To be eligible for a scholarship, the recipient must be a public/consumer member of a state medical board who has served in that capacity for no more than two (2) years or has not attended a previous FSMB Annual Meeting. Additionally, the public member *must not be eligible for a scholarship in any other capacity*.

Scholarship recipients *must* attend the entire Annual Meeting (Thursday-Saturday, April 24-26, 2014 at the Hyatt Regency Denver – Colorado Convention Center). Only one public/consumer member per state board may receive the award.

Applications will be accepted through **December 2** and is *on a first-come first-serve basis*. An application form is attached and should be submitted by email or fax to:

Jon V. Thomas, MD, Chair  
Federation of State Medical Boards  
c/o Pat McCarty  
Director of Leadership Services  
[pmccarty@fsmb.org](mailto:pmccarty@fsmb.org)  
Fax: 817-868-4167

We are very excited to offer these scholarships for public members to encourage their participation at our Annual Meeting. For questions, you may contact Pat McCarty at 817-868-4067 or [pmccarty@fsmb.org](mailto:pmccarty@fsmb.org).

Sincerely,

A handwritten signature in black ink that reads "Jon Thomas MD". The signature is written in a cursive style.

Jon V. Thomas, MD  
FSMB Chair, FSMB Board of Directors

Enclosure as stated

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

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Joshua Archiquette, Bureau Assistant		<b>2) Date When Request Submitted:</b>  11/7/13 <small>Items will be considered late if submitted after 4:30 p.m. and less than 8 work days before the meeting.</small>	
<b>3) Name of Board, Committee, Council, Sections:</b> Medical Examining Board			
<b>4) Meeting Date:</b>  11/20/2013	<b>5) Attachments:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b> FSMB Matters Minimum Data Set Pilot Implementation Project	
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	<b>8) Is an appearance before the Board being scheduled?</b>  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>	
<b>10) Describe the issue and action that should be addressed:</b>  The Board will discuss the Minimum Data Set Pilot Implementation Project			
<b>11) Authorization</b>			
Signature of person making this request			Date
Supervisor (if required)			Date
Executive Director signature (indicates approval to add post agenda deadline item to agenda)    Date			
<b>Directions for including supporting documents:</b> 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:** [Ryan, Thomas - DSPS](#)  
**To:** [Archiquette, Joshua N - DSPS](#)  
**Cc:** ["Simons, Kenneth"](#)  
**Subject:** FW: Minimum Data Set Pilot  
**Date:** Thursday, November 07, 2013 8:12:45 AM  
**Attachments:** [MDS Questions FSMB 2013.doc.doc.doc](#)  
[FSMB Framework for a Minimal Physician Data Set.pdf.pdf.pdf](#)  
**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  
817-868-4044 direct | 817-868-4144 fax  
[www.fsmb.org](http://www.fsmb.org)



## Workgroup to Define a Minimal Data Set

Report on a Recommended Framework for a Minimal  
Physician Data Set

April 2012

## TABLE OF CONTENTS

Participants	3
Introduction and Charge	4
Importance of a Minimal Physician Data Set	5
Methodology	6
Framework for a Minimal Physician Data Set	7
Graphic Representation of a Minimal Physician Data Set	9
Recommended Data Elements for a Minimal Physician Data Set	10
Recommended Questions for a Minimal Physician Data Set	11
Conclusion	16
References	17

## **PARTICIPANTS ON THE WORKGROUP TO DEFINE A MINIMAL DATA SET**

### **WORKGROUP MEMBERS**

Richard A. Whitehouse, Esq., CMBE, Chair  
Board of Directors, Federation of State Medical Boards  
Executive Director, State Medical Board of Ohio

Mark A. Eggen, MD  
Minnesota Board of Medical Practice

William L. Gant, MEd  
Chair, Washington Board of Osteopathic Medicine and Surgery

Margaret (Meg) B. Hansen, PA-C, MPAS  
Executive Director, South Dakota Board of Medical and Osteopathic Examiners

Dinesh Patel, MD, FACS  
Partners Healthcare, Massachusetts

Linda K. Whitney, MA  
Executive Director, Medical Board of California

### **EX OFFICIO**

Janelle A. Rhyne, MD, MA, MACP  
Chair, Federation of State Medical Boards  
Past President, North Carolina Medical Board

Lance A. Talmage, MD  
Chair-elect, Federation of State Medical Boards  
State Medical Board of Ohio

### **STAFF**

Aaron Young, PhD  
Senior Director, Research and Analytics  
Federation of State Medical Boards

Michael P. Dugan, MBA  
Chief Information Officer  
Federation of State Medical Boards

Humayun J. Chaudhry, DO  
President and CEO  
Federation of State Medical Boards

Sheila R. Still  
Admin Asst, Education and Library  
Federation of State Medical Boards

**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.<sup>i</sup> 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.<sup>ii</sup> 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.<sup>iii</sup> By 2030, all boomers will be 65 years of age or older and represent nearly 20% of the total population.<sup>iv</sup> Health-care reform, a growing and aging population combined with a projected physician shortage as high as 130,000 by 2025,<sup>v</sup> 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.<sup>vi</sup> 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

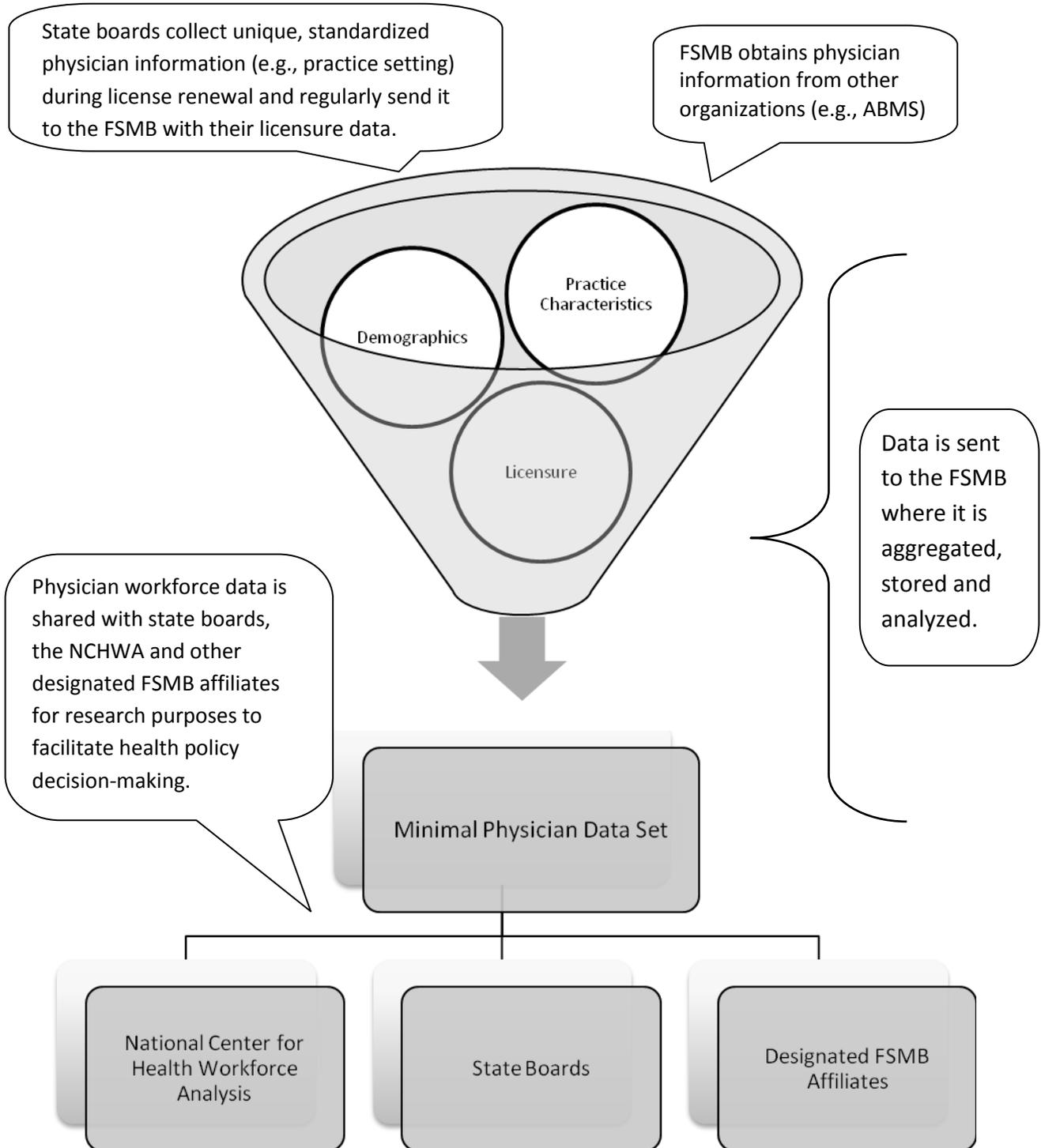
After reviewing applicable health workforce literature and analyzing information from state boards and the National Center for Health Workforce Analysis (NCHWA), the MDS Workgroup agreed that **a state board's license renewal process is a unique opportunity for collecting additional, up-to-date workforce 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?

<b>Practice Setting</b>	<b>Principal</b>	<b>Secondary</b>
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.

## REFERENCES

---

- <sup>i</sup> *H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation)*. s.l. : Congressional Budget Office, 2010.
- <sup>ii</sup> *Projections of the Population and Components of Change for the United States: 2010 to 2050 (NP2008-T1)* . s.l. : Population Division, U.S. Census Bureau, 2008.
- <sup>iii</sup> Cohn, D’Vera and Taylor, Paul. *Baby Boomers Approach Age 65 -- Glumly: Survey Findings about America's Largest Generation*. s.l. : Pew Research Center, 2010.
- <sup>iv</sup> *Projections of the Population by Selected Age Groups and Sex for the United States: 2010 to 2050 (NP2008-T2)*. s.l.: Population Division, U.S. Census Bureau, 2008.
- <sup>v</sup> *Physician Shortages to Worsen Without Increases in Residency Training*. s.l. : AAMC Center for Workforce Studies, 2010.
- <sup>vi</sup> Young A, Chaudhry H, Rhyne J, Dugan M. A Census of Actively Licensed Physicians in the United States, 2010. *Journal of Medical Regulation*. 2010-11, Vol. 96 (4).

Federation of State Medical Boards of the United States Inc.  
400 Fuller Wiser Road, Suite 300, Euless, TX  
(817) 868-4000 [www.fsmb.org](http://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)

Page intentionally left blank

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

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Joshua Archiquette, Bureau Assistant		<b>2) Date When Request Submitted:</b>  11/7/13 <small>Items will be considered late if submitted after 4:30 p.m. and less than 8 work days before the meeting.</small>	
<b>3) Name of Board, Committee, Council, Sections:</b> Medical Examining Board			
<b>4) Meeting Date:</b>  11/20/2013	<b>5) Attachments:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b> FSMB Matters Call for Nominations	
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	<b>8) Is an appearance before the Board being scheduled?</b>  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>	
<b>10) Describe the issue and action that should be addressed:</b>  The Board will consider the FSMB call for nominations			
<b>11) Authorization</b>			
Signature of person making this request			Date
Supervisor (if required)			Date
Executive Director signature (indicates approval to add post agenda deadline item to agenda)			Date
<b>Directions for including supporting documents:</b> 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.			



**DATE:** October 14, 2013

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

**FROM:** Nominating Committee Chair Lance A. Talmage, MD  
Nominating Committee Members Deeni Bassam, MD, Tariq H. Butt, MD,  
Mark A. Eggen, MD, Anna Z. Hayden, DO, Jerry G. Landau, JD, and  
Sheldon A. Wasserman, MD

**RE:** SECOND Call for Nominations of Candidates for Elective Office

---

**Nominations of Candidates for Elective Office**

Lance A. Talmage, MD, Chair of the FSMB’s Nominating Committee, requests that Member Boards and Fellows of the FSMB submit names of individuals for the Nominating Committee to consider as candidates for elective office. Elections will be held at the FSMB’s April 26, 2014 House of Delegates annual business meeting. Nominees may include physicians as well as non-physicians who are Fellows of the FSMB. The FSMB Bylaws state: *An individual member who as a result of appointment holds full time membership on a Member Medical Board shall be a Fellow of the FSMB during the member’s period of service on a Member Medical Board, and for a period of 36 months thereafter.* Instructions for recommending candidates, including eligibility requirements with responsibilities of elected positions, are attached for your information. **Please refer to this information when submitting your letters of recommendation for consideration by the Nominating Committee.**

Under the FSMB Bylaws, the Nominating Committee must nominate one or more candidates for each position. Positions to be filled in 2014 are as follows:

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

The Nominating Committee requests that all recommendations for nominations be submitted by **January 6, 2014**. **No nominations will be accepted after January 6.**

**\*Should a current Director(s) on the Board, whose term is not scheduled to expire in 2014, be elected Chair-elect, then an additional Fellow(s) will be elected as a Director(s) to complete the unexpired term(s).**

**\*\*No two Nominating Committee members shall be from the same member board. Continuing members of the Committee will be from Florida Osteopathic, Illinois, and Virginia.**

## INSTRUCTIONS FOR RECOMMENDING CANDIDATES FOR NOMINATION TO FSMB ELECTED POSITIONS

### Eligibility

Any person who is or will be a Fellow of the FSMB **at the time of the election on April 26, 2014** is eligible for nomination. The Bylaws of the FSMB define Fellows as: *An individual member who as a result of appointment holds full time membership on a Member Medical Board shall be a Fellow of the FSMB during the member's period of service on a Member Medical Board, and for a period of 36 months thereafter.*

### Core Competencies of Candidates

A candidate for elective office should:

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

### Letter of Recommendation - Contents

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

### Attachments to Letter of Recommendation

The following materials should accompany the letter of recommendation:

1. **Candidate's General Information Questionnaire (attached).** In the interest of uniformity and fairness to all candidates, the Nominating Committee requests that the information contained on the Candidate's General Information Questionnaire be limited to the space provided, *except where otherwise stated.*
2. **Signatory Form (attached).** The candidate must submit a signed confirmation that the candidate 1) will be a Fellow as defined by the FSMB Bylaws at the time of the election on Saturday, April 26, 2014; 2) is aware of the time commitment required for the position to which he/she may be elected; and 3) is disclosing any potential conflict(s) of interest.
3. **Candidate's photograph – color or black/white.** Copies of the photos will be included in the Nominating Committee meeting agenda book. If the nominee is selected, the photos will also be used in the Election Manual that is distributed at the Annual Meeting and placed on the Candidates Website. **Questions regarding photos should be directed to David Hooper, Sr. Director of Marketing, at 817-868-4070 or [dhooper@fsmb.org](mailto:dhooper@fsmb.org).**
4. **Personal statement by the candidate (sample attached) – in WORD version no greater than 500 words.** The candidate should state why he/she wants to serve in the particular position in which he/she will be campaigning for election; how he/she fulfills the core competencies of candidates, and what he/she will contribute to FSMB. The personal statement will be included in the Election Manual and placed on the Candidates Website.

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

**Deadline for Submission of Letters and Materials**

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

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

The National Office should receive letters and accompanying materials by **January 6, 2014**. **No nominations will be accepted after January 6.**

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

# RESPONSIBILITIES OF ELECTED POSITIONS

## **Board of Directors**

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

### GENERAL RESPONSIBILITIES

The Board of Directors is responsible for the following:

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

### TIME COMMITMENT

The Board of Directors will meet five times during the 2014-2015 fiscal year:

April 27, 2014 – Denver, CO (immediately following the Annual Meeting)

July 2014 – site and actual dates TBD

October 2014 – Washington, DC and actual dates TBD

February 2015 – site and actual dates TBD

April 21-26, 2015 – Fort Worth, TX (in conjunction with the Annual Meeting)

Newly elected directors will also be asked to participate in a New Directors Orientation scheduled June 1-2, 2014 at the FSMB Euless, TX Office.

The dates above include travel days.

## Nominating Committee

### COMMITTEE CHARGE

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

Tasks of the Committee include:

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

### TIME COMMITMENT

Members of the Nominating Committee serve two-year terms. The Committee will have its kick-off session in Denver, CO on the morning of Sunday, April 27, 2014 directly after the FSMB's Annual Meeting. The Committee will meet again via teleconference in July 2014 (date to be determined) and at the FSMB Eules, TX Office in January 2015.

**CANDIDATE'S GENERAL INFORMATION QUESTIONNAIRE**

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

*GENERAL*

NAME: \_\_\_\_\_

CANDIDATE FOR: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

DAYTIME TELEPHONE: \_\_\_\_\_

EMAIL AND/OR FAX: \_\_\_\_\_

*EDUCATION*

UNDERGRADUATE: \_\_\_\_\_

MEDICAL SCHOOL/GRADUATE SCHOOL: \_\_\_\_\_  
\_\_\_\_\_

POSTGRADUATE EDUCATION: \_\_\_\_\_  
\_\_\_\_\_

CURRENT POSITION: \_\_\_\_\_

AREA OF SPECIALIZATION: \_\_\_\_\_

*FEDERATION ACTIVITIES*

BOARD and/or COMMITTEES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

OTHER FSMB ACTIVITIES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**CANDIDATE SIGNATORY PAGE**

*STATE MEDICAL BOARD ACTIVITIES*

On which state medical board are you currently serving?

\_\_\_\_\_

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

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

\_\_\_\_\_

- I will be a Fellow as defined by the FSMB Bylaws at the time of the election on Saturday, April 26, 2014 and understand that only an individual who is a Fellow at the time of the individual's election shall be eligible for election. The Bylaws of the FSMB defines Fellow as:  
*An individual member who as a result of appointment holds full time membership on a Member Medical Board shall be a Fellow of the FSMB during the member's period of service on a Member Medical Board, and for a period of 36 months thereafter.*
- I am aware of the time commitment for the position I wish to be elected.
- I am disclosing any potential conflict(s) of interest.

**SIGNATURE:** \_\_\_\_\_

Potential Conflict(s) of Interest

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SAMPLE PERSONAL STATEMENT [500 words or less]

*Please provide this document in WORD format*

NAME: \_\_\_\_\_

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

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

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

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

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

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

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



STATE OF WISCONSIN  
MEDICAL EXAMINING BOARD

-----  
IN THE MATTER OF RULE-MAKING : 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 1.02 (2), relating to copy of diploma requirement.

Analysis prepared by the Department of Safety and Professional Services.

-----  
ANALYSIS

**Statutes interpreted:**

s. 448.05 (2), Stats.

**Statutory authority:**

ss. 15.08 (5) (b), 227.11 (2) (a), 448.05 (2), and 448.40, (1) Stats.

**Explanation of agency authority:**

The Medical Examining Board, (Board), pursuant to ss. 15.08 (5) (b) and 227.11, Stats., has the general power to promulgate rules for guidance within the profession and to interpret the statutes it enforces. Section 448.40 (1), Stats., grants the Board authority to promulgate rules that carry out the purposes of the Medical Practices Act. The Board seeks to interpret a statute that it administers specifically, s. 448.05 (2), Stats., which deals with applicants being required to possess a diploma. Therefore, the Board is both generally and specifically empowered to promulgate the proposed rule.

**Related statute or rule:**

None.

**Plain language analysis:**

The proposed rule seeks to amend Wis. Admin Code Med 1.02 (2) by eliminating the requirement that applicants provide a verified photographic copy of their diploma when applying for licensure. The requirement is duplicative and unnecessary since the board receives information regarding graduation directly from medical and osteopathic schools of medicine.

Section 1. amends Med 1.02 (2) by deleting the language pertaining to a copy of the applicant's diploma.

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

None.

**Comparison with rules in adjacent states:**

**Illinois:**

Illinois requires an official transcript and diploma or an official transcript and certification of graduation from the medical school. 68 Ill. Adm. Code 1285.70.

**Iowa:**

Iowa requires a copy of the applicant's medical degree and a certification from the medical school. 653 IAC 9.4 (147,148).

**Michigan:**

Michigan requires that an applicant establish that he or she is a graduate of medical school. Mich. Admin. Code R 338.2317.

**Minnesota:**

Minnesota requires an original or certified copy of the diploma from the medical or osteopathic school. Minn. R. 5600.0200 Subp. 2.

**Summary of factual data and analytical methodologies:**

The Medical Examining 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 [Greg.Gasper@wisconsin.gov](mailto:Greg.Gasper@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 Greg.Gasper@wisconsin.gov, or by calling (608) 266-8608.

**Agency contact person:**

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

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

Comments may be submitted to Shawn Leatherwood, Department of Safety and Professional Services, Division of Board Services, 1400 East Washington Avenue, Room 151, P.O. Box 8935, Madison, WI 53708-8935, or by email to Shancethea.Leatherwood@wisconsin.gov. Comments must be received on or before November 20, 2013 to be included in the record of rule-making proceedings.

---

TEXT OF RULE

SECTION 1. Med 1.02 (2) is amended to read:

Med 1.02 (2) Verified documentary evidence of graduation from a medical or osteopathic school approved by the board and ~~a verified photographic copy of the diploma conferring the degree of doctor of medicine or doctor of osteopathy granted to the applicant by such school.~~ The board recognizes as approved those medical or osteopathic schools recognized and approved at the time of the applicant's graduation therefrom by the council on medical education and hospitals of the American medical association, or the American osteopathic association, or the liaison committee on medical education, or successors. If an applicant is not a graduate of a medical school approved by the board, but is a graduate of a medical school recognized and listed as such by the world health organization of the united nations, such applicant shall submit verified documentary evidence of graduation from such school ~~and a verified photographic copy of the diploma conferring the degree of doctor of medicine or equivalent degree as determined by the board granted to the applicant by such school~~ and also verified documentary evidence of having passed the examinations conducted by the educational council for foreign medical graduates or successors, and shall also present for the board's inspection the originals thereof, and if such medical school requires either social service or internship or both of its graduates, and if the applicant has not completed either such required social service or internship or both, such applicant shall also submit verified documentary evidence of having completed a 12 month supervised clinical training program under the direction of a medical school approved by the board.

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 \_\_\_\_\_

Member of the Board  
Medical Examining Board

Page intentionally left blank

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

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Shawn Leatherwood		<b>2) Date When Request Submitted:</b> November 5, 2013  Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> <li>▪ 10 work days before the meeting for Medical Board</li> <li>▪ 14 work days before the meeting for all others</li> </ul>	
<b>3) Name of Board, Committee, Council, Sections:</b> Medical Examining Board			
<b>4) Meeting Date:</b> November 20, 2013	<b>5) Attachments:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b> Clearinghouse Report Review of Med 1.02 CR 13-090	
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	<b>8) Is an appearance before the Board being scheduled? If yes, who is appearing?</b>  <input type="checkbox"/> Yes by _____ (name)  <input checked="" type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b> N/A	
<b>10) Describe the issue and action that should be addressed:</b>  The Board will review and discuss the Clearinghouse Report and decide whether to accept or reject the recommendations made by Legislative Council.			
<b>11) Authorization</b>			
Shawn Leatherwood		November 5, 2013	
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	
<b>Directions for including supporting documents:</b> <ol style="list-style-type: none"> <li>1. This form should be attached to any documents submitted to the agenda.</li> <li>2. Post Agenda Deadline items must be authorized by a Supervisor and the Board Services Bureau Director.</li> <li>3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.</li> </ol>			



---

---

## WISCONSIN LEGISLATIVE COUNCIL RULES CLEARINGHOUSE

---

---

Scott Grosz and Jessica Karis-Ruplinger  
*Clearinghouse Co-Directors*

Terry C. Anderson  
*Legislative Council Director*

Laura D. Rose  
*Legislative Council Deputy Director*

### CLEARINGHOUSE REPORT TO AGENCY

[THIS REPORT HAS BEEN PREPARED PURSUANT TO S. 227.15, STATS. THIS IS A REPORT ON A RULE AS ORIGINALLY PROPOSED BY THE AGENCY; THE REPORT MAY NOT REFLECT THE FINAL CONTENT OF THE RULE IN FINAL DRAFT FORM AS IT WILL BE SUBMITTED TO THE LEGISLATURE. THIS REPORT CONSTITUTES A REVIEW OF, BUT NOT APPROVAL OR DISAPPROVAL OF, THE SUBSTANTIVE CONTENT AND TECHNICAL ACCURACY OF THE RULE.]

#### CLEARINGHOUSE RULE 13-090

AN ORDER to amend Med 1.02 (2), relating to copy of diploma requirement.

Submitted by **DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES**

10-14-2013 RECEIVED BY LEGISLATIVE COUNCIL.

11-05-2013 REPORT SENT TO AGENCY.

SG:DM

**LEGISLATIVE COUNCIL RULES CLEARINGHOUSE REPORT**

This rule has been reviewed by the Rules Clearinghouse. Based on that review, comments are reported as noted below:

1. STATUTORY AUTHORITY [s. 227.15 (2) (a)]

Comment Attached      YES       NO

2. FORM, STYLE AND PLACEMENT IN ADMINISTRATIVE CODE [s. 227.15 (2) (c)]

Comment Attached      YES       NO

3. CONFLICT WITH OR DUPLICATION OF EXISTING RULES [s. 227.15 (2) (d)]

Comment Attached      YES       NO

4. ADEQUACY OF REFERENCES TO RELATED STATUTES, RULES AND FORMS [s. 227.15 (2) (e)]

Comment Attached      YES       NO

5. CLARITY, GRAMMAR, PUNCTUATION AND USE OF PLAIN LANGUAGE [s. 227.15 (2) (f)]

Comment Attached      YES       NO

6. POTENTIAL CONFLICTS WITH, AND COMPARABILITY TO, RELATED FEDERAL REGULATIONS [s. 227.15 (2) (g)]

Comment Attached      YES       NO

7. COMPLIANCE WITH PERMIT ACTION DEADLINE REQUIREMENTS [s. 227.15 (2) (h)]

Comment Attached      YES       NO



---

## WISCONSIN LEGISLATIVE COUNCIL RULES CLEARINGHOUSE

---

Scott Grosz and Jessica Karls-Ruplinger  
*Clearinghouse Co-Directors*

Terry C. Anderson  
*Legislative Council Director*

Laura D. Rose  
*Legislative Council Deputy Director*

### CLEARINGHOUSE RULE 13-090

#### Comments

**[NOTE: All citations to “Manual” in the comments below are to the Administrative Rules Procedures Manual, prepared by the Legislative Reference Bureau and the Legislative Council Staff, dated November 2011.]**

#### **4. Adequacy of References to Related Statutes, Rules and Forms**

In the plain language analysis, the citation to the provision amended should include “s.” before the administrative code provision. “Wis. Admin Code” can be deleted. [s. 1.07 (2), Manual.]

#### **5. Clarity, Grammar, Punctuation and Use of Plain Language**

- a. The word “board” should be capitalized in the introductory clause.
- b. The sentence under the heading “Summary of factual data and analytical methodologies” appears to contain an error. Perhaps the word “that” should be inserted before “were”.
- c. The statutory authority section contains a misplaced comma. In that section, “448.40, (1) Stats.” should be replaced with “448.40 (1), Stats.”

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

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Shawn Leatherwood		<b>2) Date When Request Submitted:</b> November 11, 2013  Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> <li>▪ 10 work days before the meeting for Medical Board</li> <li>▪ 14 work days before the meeting for all others</li> </ul>	
<b>3) Name of Board, Committee, Council, Sections:</b> Medical Examining Board			
<b>4) Meeting Date:</b> November 20, 2013	<b>5) Attachments:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b> Legislative Report Review of Med 1.02 CR 13-090	
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	<b>8) Is an appearance before the Board being scheduled? If yes, who is appearing?</b>  <input type="checkbox"/> Yes by _____ (name)  <input checked="" type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b> N/A	
<b>10) Describe the issue and action that should be addressed:</b>  The Board will approve the Legislative Report and Draft for Clearinghouse Rule 13-090 revising Med 1.02 for submission to the Legislature.			
<b>11) Authorization</b>			
Shawn Leatherwood		November 11, 2013	
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	
<b>Directions for including supporting documents:</b> 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 :  
PROCEEDINGS BEFORE THE : REPORT TO THE LEGISLATURE  
MEDICAL EXAMINING BOARD : CR 13-090  
:  
:**

---

**I. THE PROPOSED RULE:**

The proposed rule, including the analysis and text, is attached.

**II. REFERENCE TO APPLICABLE FORMS:**

None.

**III. FISCAL ESTIMATE AND EIA:**

The Fiscal Estimate and EIA is attached.

**IV. DETAILED STATEMENT EXPLAINING THE BASIS AND PURPOSE OF THE PROPOSED RULE, INCLUDING HOW THE PROPOSED RULE ADVANCES RELEVANT STATUTORY GOALS OR PURPOSES:**

The proposed rules advances the statutory goal of s. 448.40, Stats., by amending s. Med 1.02 to eliminate the requirements that applicants for a license to practice medicine and surgery submit a verified photographic copy of the diploma conferring the degree of doctorate of medicine or doctorate of osteopathy. Currently, s. Med 1.02 requires applicants for medical licensure to file both documentary evidence from a medical school or osteopathic school of medicine and a verified photographic copy of their diploma. Since the necessary information is readily supplied by the medical or osteopathic school, there is no need for applicants to provide a verified photographic copy of their diploma. Also diplomas are more susceptible to fraud than verification directly from the school.

**V. SUMMARY OF PUBLIC COMMENTS AND THE BOARD'S RESPONSES, EXPLANATION OF MODIFICATIONS TO PROPOSED RULES PROMPTED BY PUBLIC COMMENTS:**

The Medical Examining Board held a public hearing on November 20, 2013. The following people either testified at the hearing, or submitted written comments:

This section will be completed after the public hearing

The Board summarizes the comments received either by hearing testimony or by written submission as follows:

This section will be completed after the public hearing

The Board or Department explains modifications to its rule	making proposal prompted by public comments as follows
--	--

**VI. RESPONSE TO LEGISLATIVE COUNCIL STAFF RECOMMENDATIONS:**

All of the remaining recommendations suggested in the Clearinghouse Report have been accepted in whole.

**VII. REPORT FROM THE SBRRB AND FINAL REGULATORY FLEXIBILITY ANALYSIS:**

This proposed rule does not have an economic impact on small business as defined in s. 227.114 (1), Stats.

Page intentionally left blank

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

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Joshua Archiquette, Bureau Assistant		<b>2) Date When Request Submitted:</b>  11/7/13 <small>Items will be considered late if submitted after 4:30 p.m. and less than 8 work days before the meeting.</small>	
<b>3) Name of Board, Committee, Council, Sections:</b> Medical Examining Board			
<b>4) Meeting Date:</b>  11/20/2013	<b>5) Attachments:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b> Legislative matters Assembly Bill 139	
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	<b>8) Is an appearance before the Board being scheduled?</b>  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>	
<b>10) Describe the issue and action that should be addressed:</b>  The Board will dicuss Assembly Bill 139 and related codes Chap. MED 18 and Wis. Statue 448.30			
<b>11) Authorization</b>			
Signature of person making this request			Date
Supervisor (if required)			Date
Executive Director signature (indicates approval to add post agenda deadline item to agenda)			
Date			
<b>Directions for including supporting documents:</b> 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.			



## 2013 ASSEMBLY BILL 139

April 5, 2013 - Introduced by Representatives J. OTT, SEVERSON, CZAJA, JACQUE, BROOKS, STRACHOTA, MARKLEIN, A. OTT, KESTELL, MURPHY, STROEBEL, NYGREN, BIES, BALLWEG, STONE, T. LARSON, ENDSLEY and LEMAHIEU, cosponsored by Senators GROTHMAN, VUKMIR, FARROW, COWLES, TIFFANY, OLSEN, DARLING, MOULTON and LASEE. Referred to Committee on Judiciary.

1     **AN ACT** *to repeal* 448.30 (1); *to amend* 448.30 (intro.); and *to create* 448.30 (7)  
2             of the statutes; **relating to:** the duty of physicians to inform patients of  
3             treatment options.

---

### *Analysis by the Legislative Reference Bureau*

Under Wisconsin's physician informed consent law, a physician who treats a patient has a duty to inform the patient about the availability of all alternate, viable medical modes of treatment and the benefits and risks of those treatments, subject to certain exceptions. A physician who fails to so inform a patient about modes of treatment may be held civilly liable for damages under tort law. The Wisconsin Supreme Court has employed a "reasonable patient standard" to determine whether a physician has fulfilled his or her duty. Under the reasonable patient standard, a physician must disclose information necessary for a reasonable person in the patient's position to make an intelligent decision with respect to the choices of treatment. The Wisconsin Supreme Court has also held that the duty to inform a patient about alternate modes of treating the patient's condition includes the duty to inform a patient about alternate modes of diagnosing the patient's condition.

This bill instead provides that any physician who treats a patient has a duty to inform the patient about the availability of reasonable alternate medical modes of treatment and the benefits and risks of those treatments, and provides that the "reasonable physician standard" is the standard for informing a patient under the physician informed consent law. The bill provides that the reasonable physician standard requires the disclosure only of information that a reasonable physician in

**ASSEMBLY BILL 139**

the same or a similar medical specialty would know and disclose under the circumstances. The bill also provides that the physician's duty does not require the disclosure of information about alternate medical modes of treatment for conditions that the physician does not believe the patient has at the time the physician informs the patient.

For further information see the *state and local* 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.** 448.30 (intro.) of the statutes is amended to read:

2           **448.30   ~~Information on alternate modes of treatment~~ Informed**  
3           **consent.** (intro.) Any physician who treats a patient shall inform the patient about  
4           the availability of all reasonable alternate, ~~viable~~ medical modes of treatment and  
5           about the benefits and risks of these treatments. The reasonable physician standard  
6           is the standard for informing a patient under this section. The reasonable physician  
7           standard requires disclosure only of information that a reasonable physician in the  
8           same or a similar medical specialty would know and disclose under the  
9           circumstances. The physician's duty to inform the patient under this section does not  
10          require disclosure of:

11           **SECTION 2.** 448.30 (1) of the statutes is repealed.

12           **SECTION 3.** 448.30 (7) of the statutes is created to read:

13           **448.30 (7)** Information about alternate medical modes of treatment for  
14           conditions that the physician does not believe the patient has at the time the  
15           physician informs the patient.

16           **SECTION 4. Initial applicability.**



## Chapter Med 18

### ALTERNATE MODES OF TREATMENT

Med 18.01 Authority, purpose and scope.

Med 18.02 Definitions.

Med 18.03 Communication of alternate modes of treatment.

Med 18.04 Exceptions to communication of alternate modes of treatment.

Med 18.05 Recordkeeping.

#### Med 18.01 Authority, purpose and scope.

(1) **AUTHORITY.** The rules in this chapter are adopted pursuant to authority in ss. 15.08 (5) (b), 227.11, and 448.40, Stats.

(2) **PURPOSE.** The purpose of the rules is to define the obligation of a physician to communicate alternate modes of treatment to a patient.

(3) **SCOPE.** The scope of the rules pertain to medical and surgical procedures which may be prescribed and performed only by a physician, as defined in s. 448.01 (5), Stats.

**History:** Cr. Register, September, 1983, No. 333, eff. 10-1-83; correction in (1) made under s. 13.93 (2m) (b) 7., Stats., Register, May, 1989, No. 401.

**Med 18.02 Definitions.** (1) “Emergency” means a circumstance in which there is an immediate risk to a patient’s life, body part or function which demands prompt action by a physician.

(2) “Experimental treatment” means a mode of treatment which has not been generally adopted by the medical profession.

(3) “Viable” as used in s. 448.30, Stats., to modify the term, “medical modes of treatment” means modes of treatment generally considered by the medical profession to be within the scope of current, acceptable standards of care.

**History:** Cr. Register, September, 1983, No. 333, eff. 10-1-83.

**Med 18.03 Communication of alternate modes of treatment.** (1) It is the obligation of a physician to communicate alternate viable modes of treatment to a patient. The communication shall include the nature of the recommended treatment, alternate viable treatments, and risks or complications of the proposed treatment, sufficient to allow the patient to make a prudent decision. In the communication with a patient, a physician shall take into consideration:

(a) A patient’s ability to understand the information;

(b) The emotional state of a patient; and,

(c) The physical state of a patient.

(2) Nothing in sub. (1) shall be construed as preventing or limiting a physician in recommending a mode of treatment which is in his or her judgment the best treatment for a patient.

**History:** Cr. Register, September, 1983, No. 333, eff. 10-1-83.

**Med 18.04 Exceptions to communication of alternate modes of treatment.** (1) A physician is not required to explain each procedural or prescriptive alternative inherent to a particular mode of treatment.

(2) In an emergency, a physician is not required to communicate alternate modes of treatment to a patient if failure to provide immediate treatment would be more harmful to a patient than immediate treatment.

(3) A physician is not required to communicate any mode of treatment which is not viable or which is experimental.

(4) A physician may not be held responsible for failure to inform a patient of a possible complication or benefit not generally known to reasonably well-qualified physicians in a similar medical classification.

(5) A physician may simplify or omit communication of viable modes of treatment if the communication would unduly confuse or frighten a patient or if a patient refuses to receive the communication.

**History:** Cr. Register, September, 1983, No. 333, eff. 10-1-83.

**Med 18.05 Recordkeeping.** A physician shall indicate on a patient’s medical record he or she has communicated to the patient alternate viable modes of treatment.

**History:** Cr. Register, September, 1983, No. 333, eff. 10-1-83.

cian assistant, if other than a licensed physician, shall provide for and not interfere with supervision of the physician assistant by a licensed physician.

(3) **PRESCRIPTIVE AUTHORITY.** A physician assistant may issue a prescription order for a drug or device in accordance with guidelines established by a supervising physician and the physician assistant and with rules promulgated by the board. If any conflict exists between the guidelines and the rules, the rules shall control.

**History:** 1975 c. 383, 421; 1983 a. 524; 1989 a. 31; 1993 a. 105; 1997 a. 67, 175.

**448.22 Anesthesiologist assistants.** (1) In this section, “supervision” means the use of the powers of direction and decision to coordinate, direct, and inspect the accomplishments of another, and to oversee the implementation of the anesthesiologist’s intentions.

(2) An anesthesiologist assistant may assist an anesthesiologist in the delivery of medical care only under the supervision of an anesthesiologist and only as described in a supervision agreement between the anesthesiologist assistant and an anesthesiologist who represents the anesthesiologist assistant’s employer. The supervising anesthesiologist shall be immediately available in the same physical location or facility in which the anesthesiologist assistant assists in the delivery of medical care such that the supervising anesthesiologist is able to intervene if needed.

(3) A supervision agreement under sub. (2) shall do all of the following:

(a) Describe the supervising anesthesiologist.

(b) Define the practice of the anesthesiologist assistant consistent with subs. (2), (4), and (5).

(4) An anesthesiologist assistant’s practice may not exceed his or her education and training, the scope of practice of the supervising anesthesiologist, and the practice outlined in the anesthesiologist assistant supervision agreement. A medical care task assigned by the supervising anesthesiologist to the anesthesiologist assistant may not be delegated by the anesthesiologist assistant to another person.

(5) An anesthesiologist assistant may assist only the supervising anesthesiologist in the delivery of medical care and may perform only the following medical care tasks as assigned by the supervising anesthesiologist:

(a) Developing and implementing an anesthesia care plan for a patient.

(b) Obtaining a comprehensive patient history and performing relevant elements of a physical exam.

(c) Pretesting and calibrating anesthesia delivery systems and obtaining and interpreting information from the systems and from monitors.

(d) Implementing medically accepted monitoring techniques.

(e) Establishing basic and advanced airway interventions, including intubation of the trachea and performing ventilatory support.

(f) Administering intermittent vasoactive drugs and starting and adjusting vasoactive infusions.

(g) Administering anesthetic drugs, adjuvant drugs, and accessory drugs.

(h) Implementing spinal, epidural, and regional anesthetic procedures.

(i) Administering blood, blood products, and supportive fluids.

(j) Assisting a cardiopulmonary resuscitation team in response to a life threatening situation.

(k) Participating in administrative, research, and clinical teaching activities specified in the supervision agreement.

(l) Supervising student anesthesiologist assistants.

(6) An anesthesiologist who represents an anesthesiologist assistant’s employer shall review a supervision agreement with the anesthesiologist assistant at least annually. The supervision

agreement shall be available for inspection at the location where the anesthesiologist assistant practices. The supervision agreement may limit the practice of an anesthesiologist assistant to less than the full scope of practice authorized under sub. (5).

(7) An anesthesiologist assistant shall be employed by a health care provider, as defined in s. 655.001 (8), that is operated in this state for the primary purpose of providing the medical services of physicians or that is an entity described in s. 655.002 (1) (g), (h), or (i). If an anesthesiologist assistant’s employer is not an anesthesiologist, the employer shall provide for, and not interfere with, an anesthesiologist’s supervision of the anesthesiologist assistant.

(8) A student in an anesthesiologist assistant training program may assist only an anesthesiologist in the delivery of medical care and may perform only medical care tasks assigned by the anesthesiologist. An anesthesiologist may delegate the supervision of a student in an anesthesiologist assistant training program to only a qualified anesthesiologist, an anesthesiology fellow, an anesthesiology resident who has completed his or her first year of residency, or an anesthesiologist assistant, but in no case may an anesthesiologist concurrently supervise, either directly or as a delegated act, more than 2 students in training to be an anesthesiologist assistant. This section shall not be interpreted to limit the number of other qualified anesthesia providers an anesthesiologist may supervise. A student in an anesthesiologist assistant training program shall be identified as a student anesthesiologist assistant or an anesthesiologist assistant student and may not be identified as an “intern,” “resident,” or “fellow.”

**NOTE:** This section is created eff. 11–1–12 by 2011 Wis. Act 160.

**History:** 2011 a. 160.

**448.23 Council on anesthesiologist assistants.** The council on anesthesiologist assistants shall guide, advise, and make recommendations to the board regarding the scope of anesthesiologist assistant practice and promote the safe and competent practice of anesthesiologist assistants in the delivery of health care services.

**History:** 2011 a. 160.

#### **448.30 Information on alternate modes of treatment.**

Any physician who treats a patient shall inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments. The physician’s duty to inform the patient under this section does not require disclosure of:

(1) Information beyond what a reasonably well-qualified physician in a similar medical classification would know.

(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.

**History:** 1981 c. 375.

**Cross-reference:** See also ch. Med 18, Wis. adm. code.

A one to three in 100 chance of a condition’s existence is not an “extremely remote possibility” under sub. (4) when very serious consequences could result if the condition is present. *Martin v. Richards*, 192 Wis. 2d 156, 531 N.W.2d 70 (1995).

A doctor has a duty under this section to advise of alternative modes of diagnosis as well as of alternative modes of treatment for diagnosed conditions. *Martin v. Richards*, 192 Wis. 2d 156, 531 N.W.2d 70 (1995).

What constitutes informed consent emanates from what a reasonable person in the patient’s position would want to know. What a physician must disclose is contingent on what a reasonable person would need to know to make an informed decision. When different physicians have substantially different success rates with a procedure and a reasonable person would consider that information material, a court may admit statistical evidence of the relative risk. *Johnson v. Kokemoor*, 199 Wis. 2d 615, 545 N.W.2d 495 (1996), 93–3099.

A hospital does not have the duty to ensure that a patient has given informed consent to a procedure performed by an independent physician. *Mathias v. St. Catherine’s Hospital, Inc.* 212 Wis. 2d 540, 569 N.W.2d 330 (Ct. App. 1997), 96–1632.

The onset of a procedure does not categorically foreclose withdrawal of a patient's consent. Withdrawal of consent removes the doctor's authority to continue and obligates the doctor to conduct another informed consent discussion. If the patient's choice of treatment, based on disclosure of all pertinent information to the patient, is known, the objective test of what a reasonable person would have chosen is not relevant. *Schreiber v. Physicians Insurance Co.* 223 Wis. 2d 417, 588 N.W.2d 26 (Ct. App. 1999), 96–3676.

As a general rule, patients have a duty to exercise ordinary care for their own health. Under limited, enumerated circumstances, contributory negligence may be a defense in an informed consent case. A doctor is not restricted to only the defenses listed under this section, but a court should be cautious in giving instructions on non-statutory defenses. *Brown v. Dibbell*, 227 Wis. 2d 28, 595 N.W.2d 358 (1999), 97–2181.

In the absence of a persistent vegetative state, the right of a parent to withhold life-sustaining treatment from a child does not exist and the need for informed consent is not triggered when life-sustaining treatment is performed. *Montalvo v. Borkovec*, 2002 WI App 147, 256 Wis. 2d 472, 647 N.W.2d 413, 01–1933.

A chiropractor has a duty of informed consent to make such disclosures as will enable a reasonable person under the circumstances confronting the patient to exercise the right to consent to or to refuse the procedure proposed or to request an alternative treatment or method of diagnosis. *Hannemann v. Boyson*, 2005 WI 94, 282 Wis. 2d 664, 698 N.W.2d 714, 03–1527.

A patient's consent to treatment is not categorically immutable once it has been given. A physician must initiate a new informed consent discussion when there is a substantial change in circumstances, be it medical or legal. Here, the decedent's post-operative complications did not at some point become a substantial change in medical circumstances necessitating a second informed consent discussion, because it was undisputed that the decedent was informed of the risks he later faced. *Hageny v. Bodensteiner*, 2009 WI App 10, 316 Wis. 2d 240, 762 N.W.2d 452, 08–0133.

This section requires any physician who treats a patient to inform the patient about the availability of all alternate, viable medical modes of treatment, including diagnosis, as well as the benefits and risks of such treatments. Although the jury determined a physician was not negligent in his standard of care for failing to employ an alternative when treating the defendant, that did not relieve the physician of the duty to inform the patient about the availability of all alternate, viable medical modes of treatment. *Bubb v. Brusky*, 2009 WI 91, 321 Wis. 2d 1, 768 N.W.2d 903, 07–0619.

Neither case law or this section limits the physician's duty to inform the patient of modes of treatment only for the final diagnosis. The distinction between conditions "related" to the final diagnosis and conditions "unrelated" to the final diagnosis finds no support in the statute or case law. A physician's duty is to inform the patient about diagnostic procedures about which a reasonable patient would want to know to make an informed, voluntary decision about his or her medical care, even if those diagnostic procedures are aimed at conditions that are unrelated to the condition that was the final diagnosis. *Jandre v. Physicians Insurance Company of Wisconsin*, 2012 WI 39, 340 Wis. 2d 31, 813 N.W.2d 627, 08–1972.

The doctrine of informed consent is limited to apprising the patient of risks that inhere to proposed treatments. It does not impose a duty to apprise a patient of any knowledge the doctor may have regarding the condition of the patient or of all possible methods of diagnosis. *McGeshick v. Choucair* 9 F.3d 1229 (1993).

**448.40 Rules.** (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.

(2) The board shall promulgate all of the following rules:

(a) Implementing s. 448.30.

(b) Establishing the scope of the practice of perfusion. In promulgating rules under this paragraph, the board shall consult with the perfusionists examining council.

(c) Establishing continuing education requirements for renewal of a license to practice perfusion under s. 448.13 (2). In promulgating rules under this paragraph, the board shall consult with the perfusionists examining council.

(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.

(f) Establishing requirements for prescription orders issued by physician assistants under s. 448.21 (3).

(g) Establishing procedures for issuing and using administrative warnings under s. 448.02 (8).

**History:** 1975 c. 383; 1981 c. 375; 1987 a. 399; 1993 a. 445; 1995 a. 27 s. 9126 (19); 1997 a. 67, 175, 311; 1999 a. 32, 180; 2001 a. 89; 2007 a. 20 s. 9121 (6) (a); 2009 a. 382.

**Cross-reference:** See also Med, Wis. adm. code.

## SUBCHAPTER III

## PHYSICAL THERAPY EXAMINING BOARD

**Cross-reference:** See also PT, Wis. adm. code.

**448.50 Definitions.** In this subchapter:

(1m) "Business entity" has the meaning given in s. 452.01 (3j).

(1r) "Diagnosis" means a judgment that is made after examining the neuromusculoskeletal system or evaluating or studying its symptoms and that utilizes the techniques and science of physical therapy for the purpose of establishing a plan of therapeutic intervention, but does not include a chiropractic or medical diagnosis.

(1v) "Examining board" means the physical therapy examining board.

(2) "Licensee" means a person who is licensed under this subchapter.

(3) "Physical therapist" means an individual who has been graduated from a school of physical therapy and holds a license to practice physical therapy granted by the examining board.

(3m) "Physical therapist assistant" means an individual who holds a license as a physical therapist assistant granted by the examining board.

(4) (a) "Physical therapy" means, except as provided in par. (b), any of the following:

1. Examining, evaluating, or testing individuals with mechanical, physiological, or developmental impairments, functional limitations related to physical movement and mobility, disabilities, or other movement-related health conditions, in order to determine a diagnosis, prognosis, or plan of therapeutic intervention or to assess the ongoing effects of intervention. In this subdivision, "testing" means using standardized methods or techniques for gathering data about a patient.

2. Alleviating impairments or functional limitations by instructing patients or designing, implementing, or modifying therapeutic interventions.

3. Reducing the risk of injury, impairment, functional limitation, or disability, including by promoting or maintaining fitness, health, or quality of life in all age populations.

4. Engaging in administration, consultation, or research that is related to any activity specified in subsds. 1. to 3.

(b) "Physical therapy" does not include using roentgen rays or radium for any purpose, using electricity for surgical purposes, including cauterization, or prescribing drugs or devices.

(5) "Sexual misconduct with a patient" means any of the following:

(a) Engaging in or soliciting a consensual or nonconsensual sexual relationship with a patient.

(b) Making sexual advances toward, requesting sexual favors from, or engaging in other verbal conduct or physical contact of a sexual nature with a patient.

(c) Intentionally viewing a completely or partially disrobed patient during the course of treatment if the viewing is not related to diagnosis or treatment.

(6) "Therapeutic intervention" means the purposeful and skilled interaction between a physical therapist, patient, and, if appropriate, individuals involved in the patient's care, using physical therapy procedures or techniques that are intended to produce changes in the patient's condition and that are consistent with diagnosis and prognosis.

**History:** 1993 a. 107; 2001 a. 70; 2009 a. 149.

Physical therapists and massage therapists are not prohibited from performing the activities that are within their respective scopes of practice, even if those activities extend in some degree into the field of chiropractic science. OAG 1–01.

**448.51 License required.** (1) Except as provided in s. 448.52, no person may practice physical therapy unless the person is licensed as a physical therapist under this subchapter.

Page intentionally left blank

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

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Joshua Archiquette, Bureau Assistant		<b>2) Date When Request Submitted:</b>  11/7/13 <small>Items will be considered late if submitted after 4:30 p.m. and less than 8 work days before the meeting.</small>	
<b>3) Name of Board, Committee, Council, Sections:</b> Medical Examining Board			
<b>4) Meeting Date:</b>  11/20/2013	<b>5) Attachments:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b> Education and Exam Matters USMLE Annual Report	
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	<b>8) Is an appearance before the Board being scheduled?</b>  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>	
<b>10) Describe the issue and action that should be addressed:</b>  The Board will dicuss the USMLE Annual Report			
<b>11) Authorization</b>			
Signature of person making this request			Date
Supervisor (if required)			Date
Executive Director signature (indicates approval to add post agenda deadline item to agenda)			Date
<b>Directions for including supporting documents:</b> 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.			



# The United States Medical Licensing Examination®: USMLE®

An Informational Overview from  
the Federation of State Medical Boards and  
the National Board of Medical Examiners

# Questions Answered by this Presentation

- What is USMLE?
- Why is USMLE important?
- How is USMLE governed?
- How is the exam developed?
- How is the standard determined?
- What is the future direction of USMLE?
- What if I need more information or data?

# What is the USMLE?

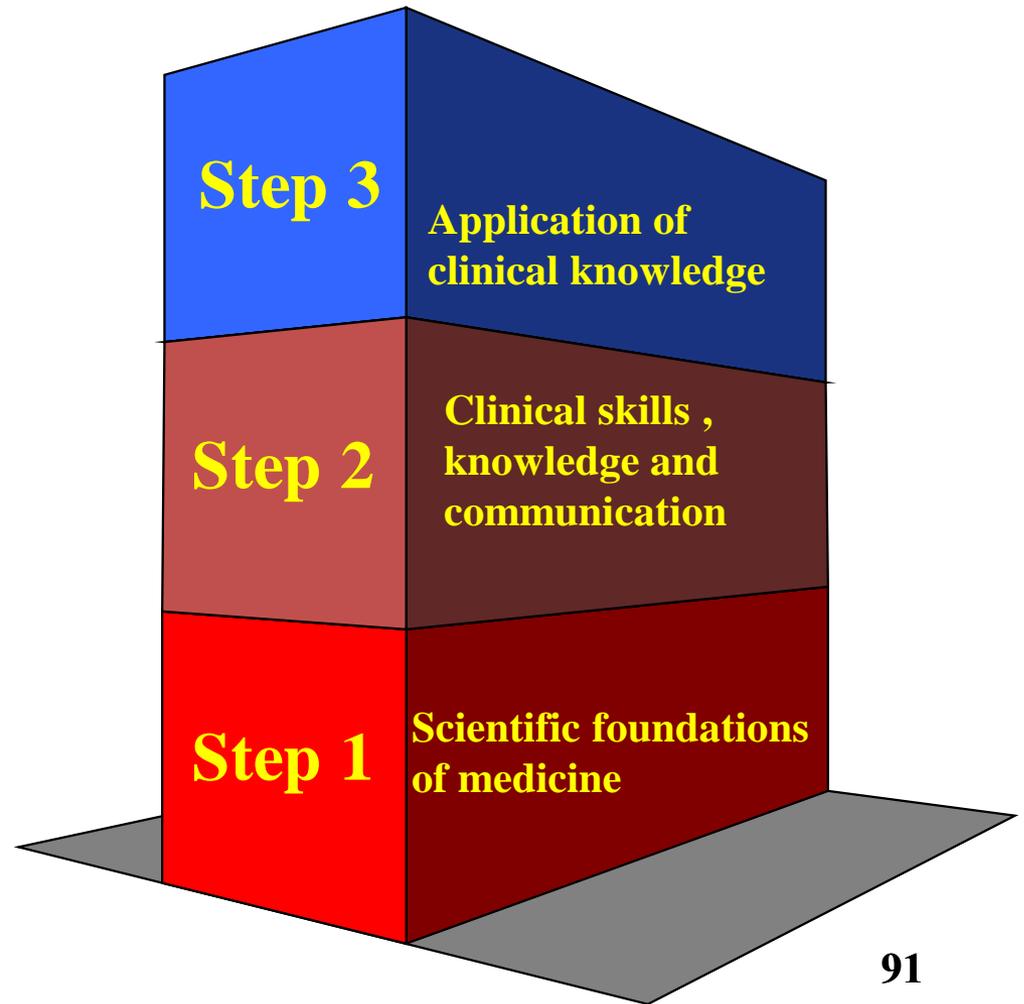
- The USMLE is a jointly sponsored program of
  - Federation of State Medical Boards (FSMB)
  - National Board of Medical Examiners (NBME)
- A required examination for graduates of accredited US medical schools granting MD degree, and all graduates of international medical schools



# USMLE

A single three Step examination for initial medical licensure

- Assesses physician cognitive, clinical and communication skills
- Provides a national standard
- Facilitates license portability
- Assists medical boards in their public protection mission



# Comparison of USMLE Components

		Step 1	Step 2		Step 3
			Clinical Knowledge (CK)	Clinical Skills (CS)	
Eligibility requirements		Medical student/graduate			MD or DO; Pass 1&2; GME*
Test administration		Offered year-round; 3 attempts/year			
Test length (days)		1	1	1	2
Format	MCQ items	325	350		480
	SP stations			12	
	CCS cases				12

\* Minimum GME requirement to sit Step 3 varies by jurisdiction

Acronyms: MCQ = multiple choice question; CCS = computer case simulation; GME = graduate medical education

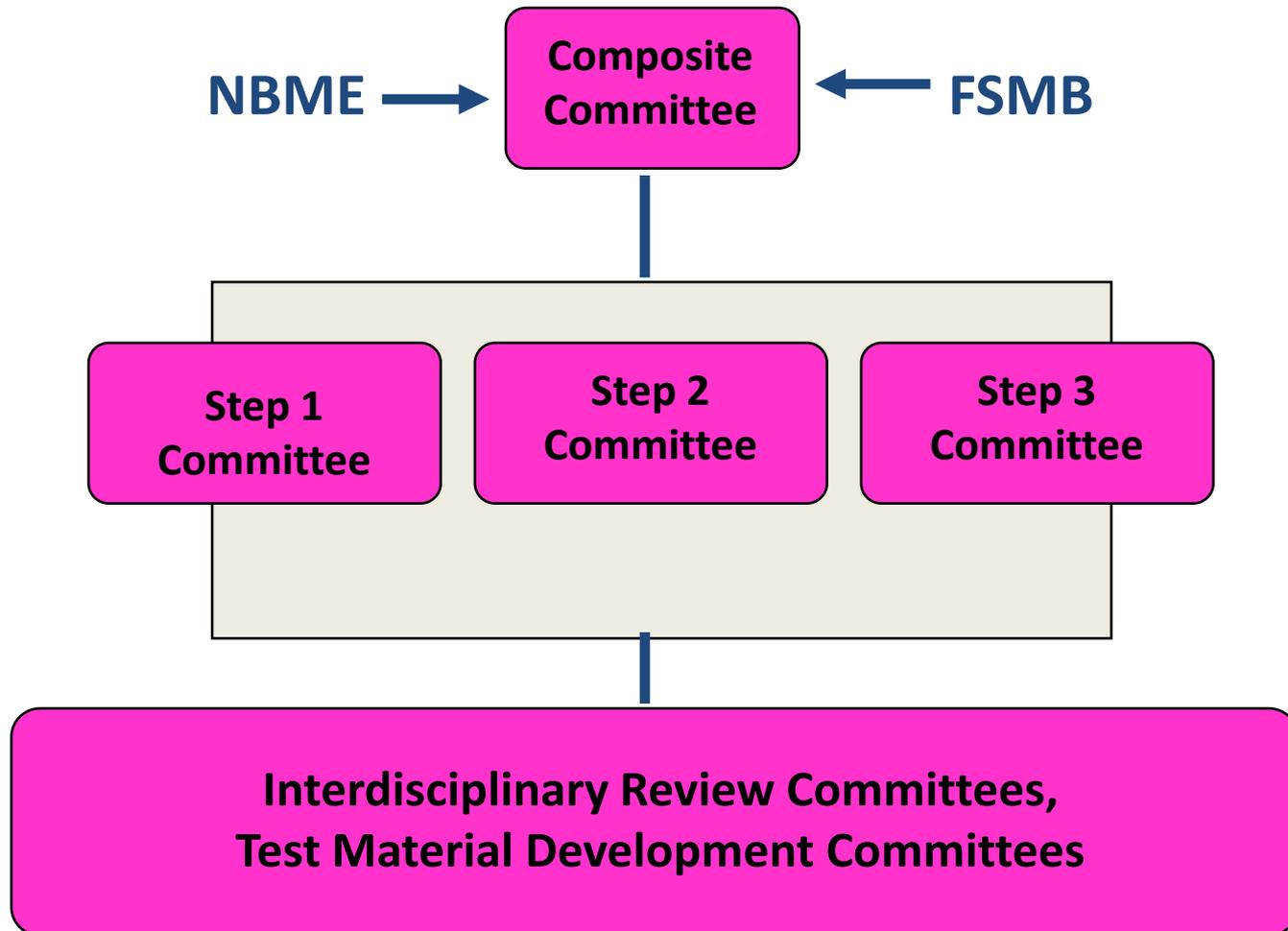
*Why is the USMLE important?*

# Users and Uses of USMLE Results

User	Step 1	Step 2	Step 3
Licensing Jurisdictions	<ul style="list-style-type: none"> <li>• Protecting the health of the public</li> <li>• Training and unrestricted medical licenses</li> </ul>		
ECFMG (IMGs only)	<ul style="list-style-type: none"> <li>• ECFMG Certification</li> <li>• Entry into GME</li> </ul>		
Medical Schools	<ul style="list-style-type: none"> <li>• Promotion &amp; graduation decisions</li> <li>• Curriculum evaluation</li> </ul>		
Residency Programs	<ul style="list-style-type: none"> <li>• Screening for interviews</li> <li>• Ranking of applicants</li> </ul>		
LCME	<ul style="list-style-type: none"> <li>• Accreditation (aggregated results)</li> </ul>		

*How is the USMLE governed?*

# USMLE Committee Structure

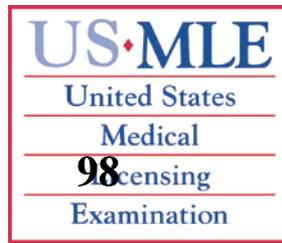


*How is the exam developed?*

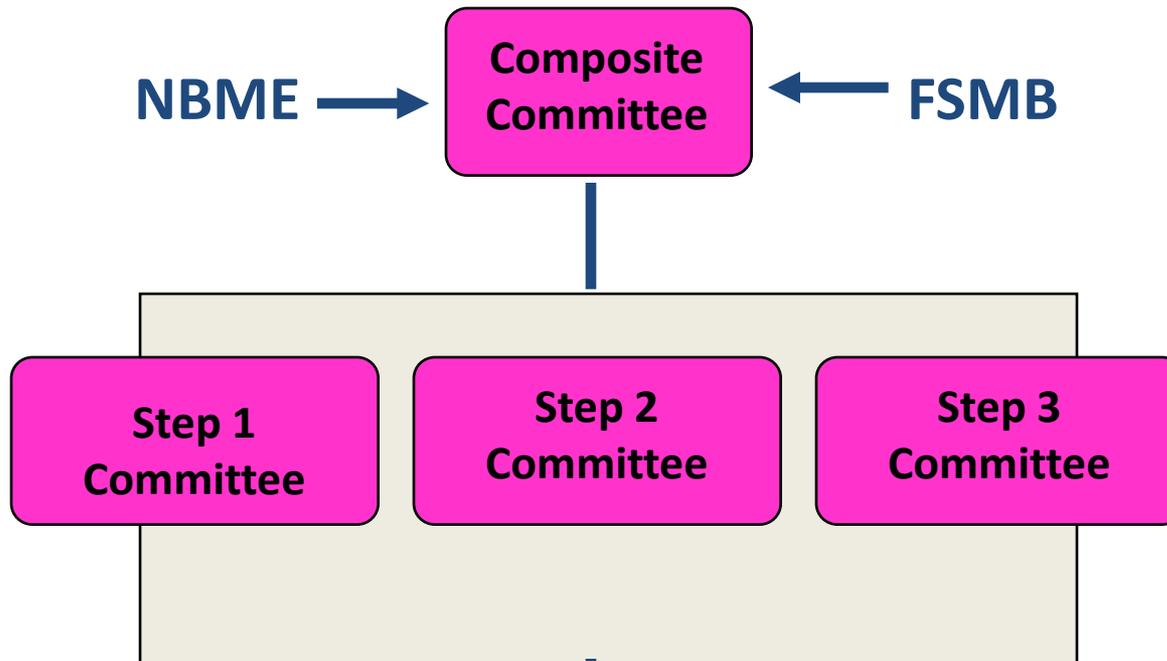
# Developing Content for USMLE

Content is developed by a “national faculty” of physicians and scientists...

- All volunteers
- Drawn from the academic, licensing and practice communities
- 300+ physicians representing specialties and expertise from across the country



# USMLE Committee Structure



Participants from 30 state boards in  
2012-2013



**Interdisciplinary Review Committees,  
Test Material Development Committees**

# USMLE Test Development

- All items and cases are developed and/or reviewed by content experts
- All pass through multiple levels of review
- All are pre-tested prior to use as live (i.e., scored) material
- Each Step or its Component uses multiple test forms
- Thousands of items and hundreds of cases in test pool for each Step

*How is the standard determined?*

# Standard setting

- The standard (i.e., minimum pass score) is set by each Step Committee
- USMLE uses an “absolute” standard
  - i.e., a minimum level of demonstrated proficiency for examinees is established in advance; there is no ‘curve’ applied.
- The standard is reviewed approximately every 4 years

# Standard setting, cont.

The Step Committee reviews information & data from variety of sources

- results from standard setting exercises involving panels of physician experts unaffiliated with USMLE
- Survey input from state boards, deans, faculty, students
- trends in examinee performance
- data on reliability of scores

*What is the future direction of the  
USMLE program?*

# Comprehensive Review of the USMLE (CRU)

- Strategic review of the program conducted 2005-2009
- Findings?
  - Reaffirmed primary purpose of USMLE as serving needs of medical licensing boards
  - A strong program that can be made even stronger
  - Changes will proceed incrementally

# Comprehensive Review of the USMLE (CRU) ...a brief update

- Multi-year review process examining purpose, use, content, formats, structure....
- Series of recommendations
  - –Refocus on licensing decisions
  - –Emphasize foundational science
  - –Reflect physician competencies
  - –Enhance clinical skills assessment
  - –Introduce evidence-based medicine
- Multi-year design/development effort

## Comprehensive Review of USMLE

Committee to Evaluate the USMLE Program (CEUP) • Summary of the Final Report and Recommendations

### EXECUTIVE SUMMARY

This document is a summary of the work and recommendations of the Committee to Evaluate the USMLE Program (CEUP), a committee constituted by the USMLE Composite Committee and comprising students, residents, clinicians, and members of the licensing, graduate, and undergraduate education communities. The goal of the committee was to determine if the mission and purpose of USMLE were effectively and efficiently supported by the current design, structure, and format of the USMLE. This process was to be guided, in part, by an analysis of information gathered from stakeholders, and was to result in recommendations to USMLE governance. The CEUP worked from 2006 to early 2008.

The USMLE examination program was designed in the late-1980s and introduced during the period 1992 to 1994. The program replaced the NBME Part Examination program and the Federation Licensing Examination (FLEX) program, which were the widely accepted medical licensing examination programs at that time. Since the introduction of USMLE, one major change in format/delivery and one major addition to the examination sequence have been implemented; these were, respectively, the transition from paper-based to computer delivery in 1999 and the introduction of a standardized patient examination in 2004. Except for these changes, and for the gradual evolution of content that occurred in response to shifts in medical practice and education, the overall structure and focus of the Step examinations have remained relatively unchanged.

To understand the rationale behind the recommendations described in this document, it is important to recognize and understand the nature of the framework that supports USMLE design, structure, and process. The values and priorities of the profession and the patients and society it serves should be reflected in the knowledge and skills tested within the licensing examination. When USMLE was first designed, early planners were clear to note that the structure of the Step examinations would reflect the knowledge and skills expected to have been acquired by students and residents as they move successfully through their training toward initial medical licensure. In recent years, educational leaders have more formally recognized and prioritized competencies that extend beyond the domains of medical science and clinical skills—competencies that are deemed important to the profession and the patients they serve but more difficult to assess using standard tools. At the same time, knowledge is expanding progressively, and the expectation that clinicians be able to draw on these fundamental insights in their approach to patients has become ever more critical. The desire to elevate the breadth and quality of assessment to meet the expectations of the broader profession and the public was a major theme in the committee's deliberations, and it has had a significant impact on the recommendations that resulted. The committee also acknowledged that any new or additional assessment tools implied by the recommendations must be rigorous, and should respect the balance between cost and value to the examinee and licensing authorities.

# CRU changes complete or underway

- Enhancements to the Step 2 Clinical Skills
  - Increased authenticity of standardized patient (SP) responses
  - New communication construct with broader range of competencies being assessed
  - New patient note with requirement to provide evidence from history and physical to support differential diagnoses

# CRU changes upcoming in 2014

- Structure, format and content changes to Step 3 will be introduced in November 2014
  - Step 3 will remain a two-day examination but with each day organized by competencies (...more to come)
  - Single, overall score and recommended pass/fail outcome
- Day 1 Foundation of Independent Practice (FIP)
- Day 2 Advanced Clinical Medicine (ACM)

# Step 3 Foundations of Independent Practice (FIP)

- Approximately 6 hour (testing time) examination
- Computer-based test
- Multiple-choice questions and innovative formats
- Expanded range of competency-based content

## Content

- Foundational Science essential for effective health care
- Biostatistics
- Epidemiology and population health
- Literature interpretation
- Patient safety
- *Professionalism*
- *Interpersonal and communication skills*
- *Systems-based practice*

# Step 3 Advanced Clinical Medicine (ACM)

- Approximately 8 hour (testing time) examination
- Computer-based test
  - Multiple-choice questions
  - Computer-based case simulations

## Content

- Health maintenance
- Diagnosis & use of diagnostic studies
- Therapeutics
- Medical decision-making

*What if I need more information?*

# Informational resources on USMLE

## *Journal of Medical Regulation*

*(Previously the Journal of Medical Licensure and Discipline)*

- Vol. 91, No. 1, 2005 USMLE Overview
- Vol. 91, No. 3, 2005 Step 2 Clinical Skills
- Vol. 92, No. 3, 2006 Maintaining Program Integrity
- Vol. 95, No. 2, 2009 Developing Test Content for USMLE
- Vol. 95, No. 4, 2009 USMLE Examinees Found to Have Engaged in Irregular Behavior

Contact the Office of the USMLE Secretariat for a complete list of research citations

USMLE website: [www.usmle.org](http://www.usmle.org)

Aggregate USMLE performance data available at <http://www.usmle.org/performance-data/>



# More informational resources

- FSMB hosts web seminars on USMLE related topics throughout the year. Prior topics include
  - Comprehensive Review of the USMLE
  - USMLE attempt limit policy
  - Upcoming changes to Step 3 in 2014
- FSMB publications such as *FSMB eNews* and *NewsLine* routinely frequently run items on USMLE
- Extensive research on USMLE has been published in professional, peer-review journals such as *Academic Medicine*

**USMLE**

United States

Medical

Licensing

Examination

# Key Contacts for USMLE

Office of the USMLE Secretariat  
3750 Market Street  
Philadelphia, PA 19104-3190  
215-590-9877

David Johnson, M.A.  
FSMB Senior Vice President for Assessment Services  
[djohnson@fsmb.org](mailto:djohnson@fsmb.org)

Gerry Dillon, Ph.D.  
NBME Vice President for Licensing Programs  
[gdillon@nbme.org](mailto:gdillon@nbme.org)

**Annual Report on the United States Medical Licensing Examination®  
(USMLE®) to Medical Licensing Authorities in the United States**

October 2013

Prepared by the Federation of State Medical Boards of the United States, Inc.,  
and the National Board of Medical Examiners®



## Table of Contents

• Introduction and Program Overview .....	3
○ Mission, vision, purpose of USMLE	
○ Governance	
○ Eligibility	
○ Content	
○ Test administration	
○ Test accommodations	
○ Score reporting	
○ Minimum passing scores	
○ Score reliability	
○ Score validity	
• USMLE Program news from 2011-2013 .....	8
○ Changes to USMLE score reporting	
○ USMLE introduces attempt limits	
○ Step 2 Clinical Skills Communication and Interpersonal Skills subcomponent and patient note changes	
○ Patient note clarification	
○ Change in the performance standard of Step 2 CS	
○ Change in the performance standard of Step 2 CK	
○ Field trial	
○ State board sponsorship role in USMLE Step 3	
• Status of the Comprehensive Review of USMLE (CRU) .....	11
○ Summary of approved recommendations	
○ New USMLE item formats	
○ Enhancements to existing USMLE item formats	
○ Restructuring of Step 3	
• Medical Licensing Authorities and the USMLE .....	13
○ FSMB webinars in 2012	
○ Annual item-writing workshop	
○ State Board Advisory Panel to USMLE	
• USMLE Data and Research .....	15
○ 2011 and 2012 USMLE performance data	
○ 2012 and 2013 USMLE research	
• Standard setting .....	17
○ Overview of standard setting process	
○ Purpose, value, importance of surveys	
○ Standard setting schedule	
• Resources .....	18
○ Websites	
○ Informational articles	
○ Key contacts	
• Appendix .....	20
○ USMLE 2011-2012 aggregate data	

## Introduction and Program Overview

The United States Medical Licensing Examination® (USMLE®) is a jointly owned program of the Federation of State Medical Boards of the United States, Inc., (FSMB) and the National Board of Medical Examiners® (NBME®). USMLE is a three-step examination sequence for medical licensure in the United States. The first administrations of the examination took place in 1992. Today, the program administers approximately 135,000 Step examinations or Step components annually.

*Mission:* The USMLE’s stated mission is to support US medical licensing authorities through the development, delivery and continual improvement of high quality assessment across the continuum of physicians’ preparation for practice. The program’s goal is to provide medical licensing authorities with “meaningful information from assessments of physician characteristics—including medical knowledge, skills, values, and attitudes—that are important to the provision of safe and effective patient care.”

The results of the USMLE are reported to medical licensing authorities for their use in the decision to grant a provisional license to practice in a post-graduate education program and an initial license to practice medicine. The USMLE is recognized and utilized by all state medical boards for licensing allopathic physicians and graduates of international medical schools. Some licensing authorities also recognize USMLE for licensing osteopathic graduates.

*Governance:* The FSMB and the NBME co-own the USMLE. However, much of the governance responsibility for the program resides with its Composite Committee. The committee comprises representatives from the FSMB, the NBME, the Educational Commission for Foreign Medical Graduates (ECFMG) and the American public. The Composite Committee is responsible for overseeing and directing USMLE policies. Specific functions of the committee include establishing policies for scoring and standard setting; approving Step examination blueprints and test formats; setting policies for test administration, test security and program research. The membership of the Composite Committee routinely includes current or former members of state medical boards. At this time, current and former members of the Minnesota, New Hampshire, North Carolina and Ohio medical boards serve on the USMLE Composite Committee.

Each of the three USMLE Step examinations is governed by a Step committee composed of physicians and scientists drawn from the licensing, practice and medical education communities. At this time, current and former members of the Florida, Hawaii, Iowa, and Wisconsin medical boards serve on USMLE Step Committees.

*Eligibility:* USMLE is intended to be taken by graduates of U.S. and Canadian medical schools granting the M.D. degree and to graduates of international medical schools, who also meet all of the requirements for eligibility that are imposed by USMLE and by the licensing jurisdiction in which the examinee intends to practice. The USMLE requirements are as follows:

To be eligible for Step 1, Step 2 CK, and Step 2 CS, the examinee must be in one of the following categories at the time of application and on test day:

- a medical student officially enrolled in, or a graduate of, a US or Canadian medical school program leading to the MD degree that is accredited by the Liaison Committee on Medical Education (LCME),
- a medical student officially enrolled in, or a graduate of, a US medical school leading to the DO degree that is accredited by the American Osteopathic Association (AOA), or

- a medical student officially enrolled in, or a graduate of, a medical school outside the United States and Canada who meets the eligibility criteria of the ECFMG.

To be eligible for Step 3, prior to submitting an application, the examinee must:

- obtain the MD degree (or its equivalent) or the DO degree,
- pass Step 1, Step 2 CK, and if required, Step 2 CS (additional information available at [www.usmle.org](http://www.usmle.org))
- obtain certification by the ECFMG or successfully complete a "Fifth Pathway" program (additional information available at [www.usmle.org](http://www.usmle.org)) if the examinee is a graduate of a medical school outside the United States and Canada, and
- meet the Step 3 requirements set by the medical licensing authority to which the examinee is applying.

The USMLE program recommends that for Step 3 eligibility, licensing authorities require the completion, or near completion, of at least one postgraduate training (PGT) year in a program of graduate medical education accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the AOA. Most state medical boards have adopted a minimum PGT requirement for Step 3. The FSMB can provide information on this and other state-specific eligibility requirements for Step 3.

A physician who received his or her basic medical degree or qualification from a medical school outside the United States and Canada may be eligible for certification by the ECFMG if the medical school and graduation year are listed in the International Medical Education Directory (IMED) of the Foundation for Advancement of International Medical Education and Research (FAIMER®). This applies to citizens of the United States who have completed their medical education in schools outside the United States and Canada but not to foreign nationals who have graduated from medical schools in the United States and Canada. Specific eligibility criteria for students and graduates of medical schools outside the United States and Canada to take Step 1 and Step 2 are described in the Information Booklet provided by the ECFMG.

Once an individual passes a USMLE Step, it may not be retaken. Rare exceptions to this policy can be found at [www.usmle.org](http://www.usmle.org).

*Content:* The USMLE is comprised of three Steps: Step 1, Step 2, and Step 3. Step 2 has two separately administered components, Clinical Knowledge (CK) and Clinical Skills (CS). Although the USMLE is generally completed over the course of several years in the career of a prospective physician, it constitutes a single examination system. Each of the three Steps complements the others; no Step can stand alone in the assessment of readiness for medical licensure.

Content for the USMLE is developed by committees of medical educators and clinicians. Committee members broadly represent the teaching, practice and licensing communities across the United States. At least two of these committees critically appraise each test item or case before it is used as live (i.e., scored) material on the USMLE. These committees may revise or discard materials for any of several reasons, e.g., inadequate clinical relevance, outdated content, failure to meet acceptable statistical performance criteria, etc. For a more detailed explanation of content development, contact FSMB for a copy of the 2009 article, "Developing Test Content for the USMLE". (*Journal of Medical Licensure and Discipline*)

Step 1 assesses whether a candidate understands and can apply important concepts of the sciences basic to the practice of medicine, with special emphasis on principles and mechanisms underlying health, disease and modes of therapy. Step 2 assesses whether the candidate can apply medical knowledge, skills and understanding of clinical science essential for providing patient care under supervision. This includes an emphasis on health promotion, disease prevention and basic patient-centered skills. Step 3 assesses whether the candidate can apply medical knowledge and understanding of biomedical and clinical science essential for the unsupervised practice of medicine with emphasis on patient management in ambulatory settings. More detail on content specifications for each USMLE Step is provided at [www.usmle.org](http://www.usmle.org).

The Step 1 examination has approximately 325 multiple-choice test items, divided into seven 60-minute blocks, administered in one eight-hour testing session. The Step 2 CK examination has approximately 350 multiple-choice test questions, divided into eight 60-minute blocks, administered in one nine-hour testing session. The Step 2 CS examination has 12 standardized patient cases, administered in a testing session of approximately eight hours. Examinees have 15 minutes for each patient encounter and 10 minutes to record each patient note. The Step 3 examination has approximately 470 multiple-choice test items, divided into blocks of 35 to 50 questions, with 45 to 60 minutes to complete each block. In addition, Step 3 includes between nine and 12 computer-based case simulations (CCS), with 10 or 20 minutes of maximum real time. Step 3 is administered in two 8-hour testing sessions.

*Test Administration:* Parts of the USMLE are administered by computer. Prometric provides scheduling and test centers for the computer-based components of the USMLE. Step 1 and Step 2 CK examinations are given around the world at Prometric Test Centers (PTCs). Step 3 is given at PTCs in the United States and its territories only. Step 2 CS is administered at five regional test centers in the United States: Atlanta, Chicago, Houston, Los Angeles, and Philadelphia.

All USMLE examinations are proctored and videotaped. Strict guidelines are followed for proper identification of examinees. Efforts are made to reduce the overlap of test content from examinee to examinee and from test day to test day. Any significant breaches in security can result in the cancellation of results, suspension of an individual from USMLE, and/or annotation of results.

*Test Accommodations:* Various test accommodations are provided in accordance with the Americans with Disabilities Act (ADA) for qualified individuals. Requests for test accommodations are reviewed by two NBME staff trained in clinical and school psychology at the doctoral level. Further review of the request and supporting documentation is provided by professionals in the respective fields of disability with whom we consult to assist NBME in making determinations regarding the presence of a disability and the appropriate accommodation(s). NBME reviews all requests for accommodations for USMLE and makes decisions for Step 1, Step 2 CK, and Step 2 CS. For Step 3, NBME provides the medical licensing authority, or its delegate, the Federation of State Medical Boards (FSMB), a recommendation regarding appropriate accommodations. Efforts are made to match accommodations to the individual's functional limitations.

Examinees protected under the ADA may be provided with a variety of accommodations. The NBME currently prepares audio recorded versions of the examinations for candidates with visual or visual processing disabilities. Special tactile versions of visual material for a Step examination may be provided for examinees with severely impaired vision. Items with an audio component may include a

visual representation of the sound for hearing impaired examinees. A sign language interpreter may be provided for deaf examinees for Step 2 CS. Examinees are informed of the availability of test accommodations in the USMLE Bulletin of Information which can be found at [www.usmle.org](http://www.usmle.org).

While presumably the use of accommodations in test activity will enable the individual to better demonstrate his/her knowledge or mastery, accommodations are not a guarantee of improved performance, test completion or a passing score. When test accommodations are granted for USMLE Steps and Step Components, score reports and transcripts may include an annotation that an accommodation was granted. Score recipients who inquire about the annotation will be provided with information about the nature of the test accommodation only.

*Score Reporting:* When examinees take Step 1, Step 2 CK, or Step 3, the computer records their responses. After the test ends, examinee responses are transmitted to the NBME for scoring. The number of test items answered correctly is converted into a 3-digit score.

On the 3-digit scale, most Step 1, 2 CK, or 3 scores fall between 140 and 260. The mean score for first-time examinees from accredited medical school programs in the United States is in the range of 215 to 235, and the standard deviation is approximately 20. Examinee score reports will include the mean and standard deviation for a recent administration of the examination.

For Step 2 CS, examinees are assessed on their physical examination and communication skills (including spoken English) by the standardized patients, and on their ability to complete an appropriate patient note by physician raters. Performance on Step 2 CS is reported as pass or fail, with no numeric score.

USMLE score reports and transcripts show scores (for Step 1, Step 2 CK, and Step 3) and an indication of whether an examinee passed or failed (for all examinations). The same information is sent to medical licensing authorities upon examinee authorization for their use in granting the initial license to practice medicine.

Except as otherwise specified below, to receive a score on Step 1, Step 2 CK, and Step 3, an examinee must begin every block of the test. If an examinee does not begin every block, no results are reported, and the "incomplete examination" attempt appears on the USMLE transcript. If an examinee registers for but does not begin an examination, no record of the test will appear on the examinee's transcript.

For Step 2 CS, if an examinee leaves the test early, or for some other reason fails to carry out one or more of the cases, performance may be assessed on those cases completed. If this assessment were to result in a passing outcome no matter how poorly an examinee may have performed on the missed case(s), then a "pass" will be reported. If this assessment were to result in a failing outcome no matter how good an examinee's performance may have been on the missed case(s), then a "fail" will be reported. Otherwise, the attempt may be recorded as an "incomplete."

Some examination materials are included in the USMLE to enhance the examination system and to investigate the measurement properties of the examinations. Such materials are not scored.

*Minimum Passing Scores:* The USMLE program provides a recommended pass or fail outcome for all Step examinations. Recommended performance standards for the USMLE are based on a specified level of proficiency. As a result, no predetermined percentage of examinees will pass or fail the examination. The recommended minimum passing level is reviewed periodically and may be adjusted at any time. Notice of such review and any adjustments will be posted at the USMLE website.

A statistical procedure ensures that the performance required to pass each test form is equivalent to that needed to pass other forms; this process also places scores from different forms on a common scale.

For Step 3, performance on the case simulations affects the Step 3 score and could affect whether examinees pass or fail. The proportional contribution of the score on the case simulations is no greater than the amount of time examinees are allowed for the case simulations.

The minimum passing scores as of October 9, 2013 are as follows:

Step 1: 188

Step 2 CK: 203

Step 3: 190

Although 2-digit scores are no longer reported, test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

*Score Reliability:* Reliability refers to a score's expected consistency. Candidates' test scores are reliable to the extent that an administration of a different random sample of items from the same content domain would result in little or no change in each candidate's rank order among a group of candidates. In general, long examinations of very similar items administered to a diverse group of examinees yield high reliabilities.

One of the ways that reliability is measured is through the standard error of measurement (SEM). The SEM provides a general indication of how much a score might vary across repeated testing using different sets of items covering similar content. As a general rule of thumb, chances are about two out of three that the reported score is within one SEM, plus or minus, of the score that truly reflects the examinee's ability (i.e., of the score that would be obtained if the examination were perfectly reliable). The current SEM is approximately 6 points for Step 1 on the three-digit reporting scale; the SEM is approximately 7 points for Step 2 CK; and the SEM is approximately 6 points for Step 3. The Step 2 CS is only reported as a pass or fail, without a reported score.

*Score Validity:* Score validity refers to the extent to which existing evidence supports the appropriateness of the interpretation of test outcomes. For USMLE, the intended interpretation of passing all examinations is that the individual has the fundamental knowledge and skills required to begin patient care in a safe and effective manner. The best way to support a proposed score interpretation is through accumulation of developmental documentation and research on all components of the test design, delivery, and scoring processes, and through tracking the relationship of examination outcomes with later measures of the individual's ability. The USMLE program has a fairly extensive history of such activity. Many of the details of USMLE processes are available at the USMLE website. Lists of research citations are available by contacting the Office of the USMLE Secretariat (contact information on page 18).

## USMLE Program News, 2011-2013

*Changes to USMLE score reporting:* Starting July 1, 2011, USMLE transcripts reported through the Electronic Residency Application Service® (ERAS®) reporting system no longer included score results on the two-digit score scale. USMLE results continue to be reported on the three-digit scale. This affects the Step 1, 2 CK, and 3 examinations only; Step 2 CS continues to be reported as pass or fail. These changes do not alter the score required to pass or the difficulty of any of the USMLE Step examinations. Since its beginning in the 1990s, the USMLE program has reported two numeric scores for the Step 1, Step 2 CK, and Step 3 examinations, one on a three-digit scale and one on a two-digit scale. The three-digit score scale is considered the primary reporting scale; it is developed in a manner that allows reasonable comparisons across time. The two-digit scale was intended to meet statutory requirements of some state medical boards that rely on a score scale that has 75 as the minimum passing score. The process used to convert three-digit scores to two-digit scores was designed in such a way that the three-digit minimum passing score in effect when the examinee tests was associated with a two-digit score of 75. To simplify matters and make interpretation of USMLE information more convenient for score users, the USMLE Composite Committee asked staff to report two-digit scores only to those score users for whom the scale is intended, i.e., the state medical boards. The Committee also asked that examinees continue to receive scores on both scales so that they were fully informed about the information that would be reported when they ask that results be sent to a state medical board. When examinees request that their results be sent to other score users, only the three-digit score would be reported. These changes began with the elimination of the two-digit score from USMLE transcripts reported through the ERAS reporting system. The USMLE program implemented the final step in this change in reporting to include ALL score recipients (e.g., examinees, state medical boards) beginning April 1, 2013. Beginning April 1, 2013, scores on the 2-digit scale were no longer calculated or reported. This change pertains to the Step 1, Step 2 CK, and Step 3 examinations only; Step 2 CS continues to be reported as pass or fail.

*USMLE introduces attempt limits:* In 2012, the USMLE program introduced a limit on the total number of times an examinee can take the same Step or Step Component. With this limit in effect, an examinee is ineligible to take a Step or Step Component if the examinee has made six or more prior attempts to pass that Step or Step Component, including incomplete attempts. The effective date for the six-attempt limit depended upon whether an examinee had taken any Step or Step Component (including incomplete attempts) before January 1, 2012. For examinees who had not taken any Step or Step Component before January 1, 2012, the six-attempt limit went into effect for all exam applications submitted on or after January 1, 2012. For examinees who had taken any Step or Step Component (including incomplete attempts) before January 1, 2012, the six-attempt limit went into effect for all exam applications submitted on or after January 1, 2013.

### *Step 2 CS Communication and Interpersonal Skills subcomponent and patient note changes*

The three subcomponents of Step 2 CS include the Integrated Clinical Encounter (ICE), Communication and Interpersonal Skills (CIS), and Spoken English Proficiency (SEP). Each subcomponent must be passed independently of the others in order to receive a passing score for the entire Step 2 CS. The CIS subcomponent of Step 2 CS has been redesigned to assess a fuller range of competencies, expanding on the functions in the original construct—professional manner and rapport, informational gathering, and information sharing. The new approach divides communication skills into a series of additional functions. These functions have been further divided into sub-functions. Beginning June 17, 2012, the Communication and Interpersonal Skills (CIS) scale focuses on five functions:

1. Fostering the relationship
2. Gathering information
3. Providing information
4. Making decisions: basic
5. Supporting emotions: basic

Several additional functions are still under development; these include advanced decision-making, advanced emotional support, and helping patients with behavior change.

*Patient note clarification:* On June 17, 2012, a new patient note was introduced. The patient note is completed by the examinee after the encounter with the standardized patient. In the new note, examinees continue to be asked to document relevant history and physical examination findings and to list initial diagnostic studies to be ordered. Examinees are also asked to create a reasoned, focused differential (maximum of three diagnoses) listed in order of likelihood. Examinees are expected to record only the most likely diagnoses along with findings (positive and negative), that support them. The new patient note provides examinees with an opportunity to document their analysis of a patient's possible diagnoses.

*Change in the performance standard of Step 2 CS:* The level of proficiency required to meet the recommended minimum passing level for each USMLE Step examination is reviewed periodically and may be adjusted at any time. At its December 2012 meeting, the Step 2 Committee conducted such a review for USMLE Step 2 Clinical Skills (CS). The Step 2 Committee decided to increase the performance levels required to receive a passing outcome on two of the three Step 2 CS subcomponents: Communication and Interpersonal Skills (CIS) and Integrated Clinical Encounter (ICE). No change has been made to minimum passing requirements for the Spoken English Proficiency (SEP) subcomponent of Step 2 CS. The changes were applied to Step 2 CS examinees testing on or after January 1, 2013. Because of the changes that were made to the design and content of the ICE and CIS subcomponents in 2012, the ability to use historical trends to predict the impact of the changes in minimum passing requirements is limited. If the new minimum passing requirements were applied to the group of first-time examinees who recently tested under the new examination structure, the overall passing rate for examinees from US medical schools would be approximately three percent lower and the overall passing rate for examinees from international medical schools would be approximately eighteen percent lower. The impact of these changes on future examinees will depend on the examinees' performance. The overall impact will be reviewed by the Step 2 Committee when more examinees have tested under these new requirements.

*Change in the performance standard for Step 2 CK:* At its June 2013 meeting, the Step 2 Committee conducted a review of the performance standard for USMLE Step 2 CK. As a result of its review, the Step 2 Committee decided to raise the Step 2 CK recommended minimum passing score from 196 to 203. The new minimum passing score became effective for all Step 2 CK examinations for which the first day of testing was on or after July 1, 2013.

*Field Trial:* The National Board of Medical Examiners® (NBME®) has developed new assessment formats for possible future use in the USMLE Step 2 Clinical Skills (CS) examination. A field trial to test these new formats and measurement instruments was conducted in August, 2013 at the NBME headquarters in Philadelphia, PA. Participants in the trial practiced a clinical skills examination administered under standard USMLE conditions.

*State board sponsorship role in USMLE Step 3:* Since the first administration of Step 3 in 1994, two sets of eligibility criteria have been applied to sitting for Step 3. These include the core USMLE requirements (e.g., passing Step 1-2; obtain the MD degree (or its equivalent) or DO degree; ECFMG certification for international medical graduates) and any requirements set by the sponsoring state medical board. Changes in the USMLE over the ensuing twenty years (e.g., shift to computer-based testing) resulted in the program assuming all registration and test administration responsibilities for Step 3 on behalf of state medical boards. In January 2013, the Composite Committee made the decision, subsequently approved by the FSMB Board of Directors, to discontinue the board sponsorship role for USMLE Step 3. In reaching this decision, the USMLE Composite Committee gave considerable weight to the results of a survey of state medical boards. In that survey 89% of boards expressed a desire to discontinue the formal board sponsorship role in setting eligibility for Step 3. This will go into effect in late 2014 when the USMLE introduces new content for the Step 3 examination.

## Status of the Comprehensive Review of USMLE (CRU)

In 1995, the membership of the NBME and the FSMB House of Delegates approved a strategic plan for the enhancement of the USMLE. This strategic plan called for two major enhancements: the move to a computer-based administration of the exam and the implementation of a clinical skills assessment into the USMLE. The objectives of this strategic plan were achieved with the shift to computer-based testing in 1999 and the addition of the Step 2 CS in 2004.

In 2005, the next generation of strategic planning began for the USMLE. Called the *Comprehensive review of USMLE (CRU)*, the recommendations arising from this strategic review were approved by NBME governance and FSMB governance in spring 2009. The major recommendations from this phase were: the USMLE should be explicitly oriented to support the licensing decisions made by state medical boards for the supervised and unsupervised practice of medicine; a general competencies schema should be adopted for the USMLE; the assessment of foundational medical sciences should be integrated throughout the USMLE sequence; the USMLE program should continue its emphasis on the assessment of clinical skills (including enhancements to the Step 2 Clinical Skills examination); and USMLE should develop new testing formats to assess an individual's ability to locate, interpret and apply medical information appropriately in a clinical context.

### *New USMLE Item Formats*

*Focus on New Competencies:* USMLE continues to develop new assessment formats to broaden the range of competencies that can be tested in computer-based components of USMLE by investigating simulated challenges to skills in patient care, professionalism, communication, systems-based practice, and other important, difficult-to-measure competencies. The tool set being considered is deliberately broad, including multiple new response formats that can be used in various combinations to flexibly assess key skills and hard-to-measure competencies. Where they improve the assessment of the skills to be measured, short video clips may be used to provide richer, more authentic depictions of clinical situations.

### *Enhancements to Existing USMLE Item Formats*

*Step 2 CS:* Enhancements to the Step 2 CS examination extend both the nature and degree of challenges faced by examinees. Research activities underway for the past several years resulted in implementation of several changes to the Step 2 CS examination in mid-June 2012. The Communications and Interpersonal Skills (CIS) subcomponent of Step 2 CS was redesigned to assess a fuller range of competencies. Research into the assessment of more advanced communications skills continues through 2013.

*Restructuring of Step 3:* Changes to the Step 3 examination will occur in 2014. The current Step 3 examination is administered in two 8-hour test sessions, which must be taken on consecutive days. The restructured examination will also consist of two test days:

**Step 3 Foundations of Independent Practice (FIP):** this test day will focus on assessment of knowledge of foundational medicine and science essential for effective health care.

Content areas covered will include applying foundational sciences; biostatistics, epidemiology/population health, and interpretation of the medical literature; and social sciences, including communication and interpersonal skills, medical ethics, and systems-based practice/patient safety. The test day will also include some content assessing

knowledge of diagnosis and management. This test day will include some of the newer item formats, such as those based on scientific abstracts and pharmaceutical advertisements.

**Step 3 Advanced Clinical Medicine (ACM):** this test day will focus on assessment of applying comprehensive knowledge of health and disease in the context of patient management. Content areas covered will include assessment of knowledge of history and physical examination, diagnosis and use of diagnostic studies, prognosis/outcome, health maintenance/screening, therapeutics, and medical decision-making. This test day will include multiple-choice questions and computer-based case simulations.

Examinees will be able to schedule the two test days on **non-consecutive** days. A **single score (with graphical performance profile information) and a single pass/fail outcome** will be reported following completion of both examination days. The restructured Step 3 examination will be administered beginning **November, 2014**. During an approximately one-month period (October, 2014), it is likely that no Step 3 examinations will be administered. Practice materials for the restructured examinations will be posted to the USMLE website in mid-2014. There will be a score delay following the introduction of the restructured examinations. Additional information will be posted as soon as it is available.

## Medical Licensing Authorities and the USMLE

In 2012, the FSMB registered approximately 31,000 applicants for the USMLE Step 3 on behalf of, and under the eligibility requirements established by, the individual state boards.. Step 1 and Step 2 registration services are provided by NBME for students and graduates in US medical and osteopathic schools and by ECFMG for students and graduates of international medical schools under eligibility requirements established by the USMLE Composite Committee.

The FSMB produced and delivered approximately 39,000 USMLE transcripts to state medical boards as part of individual physicians' applications for medical licensure. This total does not include the 15,000 transcripts produced as part of the Federation Credentials Verification System profile sent to state medical boards for physicians seeking licensure.

The USMLE makes a wide range of informational materials available to medical licensing authorities on the program. A series of informational articles on USMLE have appeared in the FSMB's *Journal of Medical Regulation* (See Section 7). Since 2009, the FSMB has hosted multiple web seminars on USMLE-related topics. Subjects covered in the 2012 webinars include USMLE attempt limit policy and an update on content changes to Step 3, including the discontinuance of state board sponsorship for Step 3. Copies of these presentations are available upon request from the FSMB.

The FSMB and NBME host an annual item-writing workshop for members of state medical boards. This free workshop is open to current and former members of state medical boards with an interest in participating in the program. The seventh and most recent workshop took place in October 2012 in Philadelphia. At that time, five physician members and board staff from the following medical boards participated: Georgia, Massachusetts, Minnesota, Ohio and Virginia. To date, 64 individuals from 38 medical and osteopathic boards have participated. Thirty-five (35) past workshop participants have served subsequently with the USMLE program. This involvement includes standard-setting and advisory panels; others are now serving on Step Committees and item-writing committees for the program. The next workshop is set for October 30, 2013. Physician and public members of state medical and osteopathic boards interested in attending this workshop should contact the FSMB for more information.

In 2011, the USMLE established an advisory panel composed of members and senior staff from state medical boards. The State Board Advisory Panel to the USMLE convened in August 2011 and August 2012 at the FSMB offices in Euless, Texas and is scheduled to meet again in September 2013. The panel provides the USMLE with firsthand feedback on timely issues and major initiatives from the primary intended user of USMLE scores – state medical boards. Topics scheduled to be addressed by the panel in September 2013 include an update on content and format changes to Step 3, the provision of total testing time in the USMLE, principles behind the release of USMLE data to third parties, new testing formats under consideration by the program, etc. The current members of the panel include staff and board members from the District of Columbia, Georgia, Iowa, Minnesota, Montana, Vermont, Virginia, West Virginia, Wisconsin and Wyoming boards.

Groups such as the State Board Advisory Panel to USMLE and outreach efforts such as the annual item-writing workshop for members of state medical boards continue the long history of the USMLE program involving the state medical board community directly in the operations of the program. Since its implementation in 1992, 179 members and staff from state medical boards have

participated in the USMLE program. These individuals represented 58 different medical and osteopathic licensing boards.

The USMLE program makes two recommendations to state medical boards relative to their use of USMLE scores. These recommendations involve limiting the number of attempts at the USMLE and the time period for completing the USMLE sequence. The USMLE program recommends that state medical boards:

- Require the dates of passing Step 1, Step 2 and Step 3 occur within a seven-year period<sup>1</sup>; and
- Allow no more than six attempts to pass each Step or Step Component without demonstration of additional educational experience acceptable to the board.

Most state medical boards utilizing the USMLE impose both time and attempt limits (see page 5 of this document for recent changes on attempt limits) on the USMLE as part of their requirements for obtaining an initial medical license. Currently, 39 out of 51 medical boards impose some limit on the number of attempts at the USMLE; 45 out of 51 medical boards impose a time limitation for the completion of the USMLE sequence. For a complete listing, please visit: [http://www.fsmb.org/usmle\\_elinitial.html](http://www.fsmb.org/usmle_elinitial.html).

---

<sup>1</sup> The USMLE also recommends that state medical boards consider additional time for individuals completing a dual degree program (MD/PhD; DO/PhD). Specific requirements are listed in the USMLE *Bulletin of Information* at [www.usmle.org](http://www.usmle.org)

## USMLE Data and Research

The USMLE program publishes aggregate performance data for all Steps since the program's inception. These data include examinee volume and passing percentages categorized by first-taker and repeater examinees; US/Canadian and international students/graduates; allopathic and osteopathic examinees. These performance data are available at the USMLE website at <http://www.usmle.org/performance-data/>.

Passing rates and examinee counts for 2011 and 2012 are provided for each Step in this report's Appendix.

Each year, the USMLE Composite Committee reviews and endorses a research agenda for the program. In 2013, the committee endorsed the following research themes and/or topics for the program: enhancements to USMLE; relating scores and pass/fail outcomes to external measures; USMLE security procedures.

Below is a list of USMLE-related publications from 2012 and 2013. A more complete listing of USMLE-related publications is available upon request.

Brown CB, Kahraman N. Exploring psychometric models to enhance standardized patient quality assurance: evaluating standardized patient performance over time. *Academic Medicine*. 2013;88:866-871.

Chavez AK, Swygert KA, Peitzman SJ, Raymond MR. Within-session score gains for repeat examinees on a standardized patient examination. *Academic Medicine*. 2013;88:688-692.

Clauser BE, Mee J, Margolis MJ. The effect of data format on integration of performance data into Angoff judgments. *International Journal of Testing*. 2013;13:65-85.

Cuddy MM, Swanson DB, Drake RL, Pawlina W. Changes in anatomy instruction and USMLE performance: empirical evidence on the absence of a relationship. *Anatomical Sciences Education*. 2013;6:3-10.

Feinberg RA, Swygert KA, Haist SA, Dillon GF, Murray CT. The impact of postgraduate training on USMLE Step 3 and its computer-based case simulation component. *Journal of General Internal Medicine*. 2012;27:65-70.

Kahraman N, De Champlain AF, Raymond MR. Modeling the psychometric properties of complex performance assessment tasks using confirmatory factor analysis: a multistage model for calibrating tasks. *Applied Measurement in Education*. 2012;25:79-95.

Raymond MR, Swygert KA, Kahraman N. Measurement precision for repeat examinees on a standardized patient examination. *Advances in Health Sciences Education: Theory and Practice*. 2012;17:325-337.

Raymond MR, Swygert KA, Kahraman N. Psychometric equivalences of ratings for repeat examinees on a performance assessment for physician licensure. *Journal of Educational Measurement*. 2012;49:339-361.

Stain SC, Hiatt JR, Ata A, Ashley SW, Roggin KK, Potts JR, Moore RA, Galante JM, Britt LD, Deveney KE, Ellison EC. Characteristics of highly ranked applicants to general surgery residency programs. *JAMA Surgery*. 2013;148(5):413-417.

Swygert KA, Cuddy MM, van Zanten M, Haist SA, Jobe AC. Gender differences in examinee performance on the Step 2 Clinical Skills data gathering (DG) and patient note (PN) components. *Advances in Health Sciences Education Theory and Practice*. 2012; 17:557-571.

Swygert KA, Haist SA. A response to "Bridging the gender gap in communication skills" by Wu and McLaughlin (2012). *Advances in Health Sciences Education: Theory and Practice*. 2013;18:133-134.

van Zanten M, McKinley DW, Durante Montiel I, Pijano CV. Medical education accreditation in Mexico and the Philippines: impact on student outcomes. *Medical Education*. 2012;46(6):568-592.

Winward ML, Lipner RS, Johnston MM, Cuddy MM, Clauser BE. The relationship between communication scores from the USMLE Step 2 Clinical Skills examination and communication ratings for first-year internal medicine residents. *Academic Medicine*. 2013;88: 693-698.

## Standard Setting

The USMLE program provides a recommended pass/fail outcome on all Step examinations, with numeric scores reported for Step 1, Step 2 CK and Step 3. The recommended performance standards for USMLE are based on a specified level of proficiency identified through a standard setting process. As a result, no predetermined percentage of examinees will pass or fail the examination.

Approximately every four years, each Step committee revisits its standard, i.e., minimum pass score. The Step 2 CK and CS standards were reviewed in 2012; the Step 1 standard is scheduled for review in December 2013; the Step 2 CK standard is scheduled for review in 2014; and the Step 3 standard is scheduled for review in 2015. In discussing the appropriateness of the current standard, Step committees consider information drawn from multiple sources:

- recommendations from independent groups of physicians who participated in content-based standard-setting activities;
- surveys from multiple groups including state board chairs and executive directors;
- trends in aggregate performance data; and
- data on score precision and its effect on the pass/fail decision.

Input from state medical boards is important to informing the decision of the Step Committee when considering the standard. Representatives from state medical boards participated in the standard setting panels for Step 1, which met in June through July of 2012. Additionally, executive director and state board presidents will be surveyed as part of the standard-setting activities. These surveys are important informational pieces, and all state boards are strongly encouraged to respond. For a more detailed discussion of the USMLE program's approach to standard setting, contact the NBME for a copy of the article "Setting Standards on the United States Medical Licensing Examination" by Drs. Dillon, Case, Melnick, Nungester and Swanson.

## Resources

*Websites:* Multiple avenues for obtaining additional information on the USMLE exist. The most current information on the program can be obtained from the USMLE website at [www.usmle.org](http://www.usmle.org). In addition, the websites of the FSMB ([www.fsmb.org](http://www.fsmb.org)) and the NBME ([www.nbme.org](http://www.nbme.org)) contain much information specific to registering for the USMLE. Students and graduates of international medical schools seeking information on the USMLE should contact the ECFMG website at [www.ecfmg.org](http://www.ecfmg.org)

*Written materials:* USMLE policies and procedures are reflected in the program's *Bulletin of Information*. The current *Bulletin of Information* can be accessed from the main page of the USMLE website. Additional USMLE information can also be found in the NBME *Examiner*, the official newsletter of the NBME. The current issue of the NBME *Examiner* and archived issues can be found under the Publications tab at [www.nbme.org](http://www.nbme.org). Informational articles summarizing major aspects of the USMLE program have appeared in the *Journal of Medical Regulation* (previously titled the *Journal of Medical Licensure and Discipline*). Topics covered in the series of USMLE articles include Step 2 Clinical Skills, the development of multiple-choice questions for test content, research and processes for maintaining program security, etc. The following articles are available upon request from the FSMB.

- “An Assessment of USMLE Examinees Found to Have Engaged in Irregular Behavior, 1992-2006.” *Journal of Medical Regulation*. Vol. 95, No. 4, 2010
- “Developing Content for the United States Medical Licensing Examination.” *Journal of Medical Licensure and Discipline*. Vol. 95, No. 2, 2009
- “Maintaining the Integrity of the United States Medical Licensing Examination.” *Journal of Medical Licensure and Discipline*. Vol. 92, No. 3, 2006
- “The Introduction of Clinical Skills Assessment into the United States Medical Licensing Examination (USMLE): A Description of the USMLE Step 2 Clinical Skills (CS).” *Journal of Medical Licensure and Discipline*. Vol. 91, No. 3, 2005.
- “The United States Licensing Examination.” *The Journal of Medical Licensure and Discipline*. Vol. 91, No. 1, 2005.

*Key contacts:* The following individuals should be considered as key contacts for state medical boards on matters involving the USMLE.

David Johnson, MA  
Federation of State Medical Boards  
Sr. Vice President for Assessment Services  
400 Fuller Wisser Road, Suite 300  
Euless, Texas 76039  
817-868-4081; [djohnson@fsmb.org](mailto:djohnson@fsmb.org)

Gerry Dillon, PhD  
National Board of Medical Examiners  
Vice President, Licensure Programs  
3750 Market Street  
Philadelphia, PA 19104-3190  
215-590-9739; [gdillon@nbme.org](mailto:gdillon@nbme.org)

Amy Buono  
Office of the USMLE Secretariat  
3750 Market Street  
Philadelphia, PA 19104-3190  
215-590-9877; [abuono@nbme.org](mailto:abuono@nbme.org)

## APPENDIX

The data tables below are extracted from the performance data provided on the USMLE website at <http://www.usmle.org/performance-data/>. Similar data are available for all years of the USMLE program.

Table 1

<b>2012 STEP 1 ADMINISTRATIONS *</b> Number Tested and Percent Passing		
	<b># Tested</b>	<b># Passing</b>
<b>Examinees from US/Canadian Schools that Grant:</b>		
MD Degree	19,856	94%
1st Takers	18,723	96%
Repeaters**	1,133	68%
DO Degree	2,564	91%
1st Takers	2,496	92%
Repeaters**	68	68%
Total US/Canadian	22,420	94%
<b>Examinees from Non-US/Canadian Schools</b>		
1st Takers	14,201	76%
Repeaters**	4,261	40%
Total non-US/Canadian	18,462	68%

Table represents data for examinees tested in 2012 and reported through February 6, 2013.

### Notes for Table 1

\* The table represents data for examinees tested in 2012 with scores reported through February 6, 2013.

\*\* The # tested listed for repeaters represent examinations given, not the number of examinees for the specified time period.

Table 2

<b>2011- 2012 STEP 2 Clinical Knowledge (CK) ADMINISTRATIONS *</b> Number Tested and Percent Passing		
	<b># Tested</b>	<b># Passing</b>
<b>Examinees from US/Canadian Schools that Grant:</b>		
MD Degree	18,929	97%
1st Takers	18,454	98%
Repeaters**	475	72%
DO Degree	1,456	96%
1st Takers	1,439	97%
Repeaters**	17	53%
Total US/Canadian	20,385	97%
<b>Examinees from Non-US/Canadian Schools</b>		
1st Takers	11,908	85%
Repeaters**	2,191	54%
Total non-US/Canadian	14,099	80%

Notes for Table 2

\* The table represents data for examinees tested July 1, 2011 through June 30, 2012.

\*\* The # tested listed for repeaters represent examinations given, not the number of examinees for the specified time period.

Table 3

<b>2011- 2012 STEP 2 Clinical Skills (CS) ADMINISTRATIONS *</b> Number Tested and Percent Passing		
	<b># Tested</b>	<b># Passing</b>
<b>Examinees from US/Canadian Schools that Grant:</b>		
MD Degree	17,118	97%
1st Takers	16,662	97%
Repeaters**	456	92%
DO Degree	46	87%
1st Takers	45	87%
Repeaters**	1	---
Total US/Canadian	17,164	97%
<b>Examinees from Non-US/Canadian Schools</b>		
1st Takers	11,515	80%
Repeaters	2,265	65%
Total non-US/Canadian	13,780	77%

Notes for Table 3

\* The table represents data for examinees tested July 1, 2011 through May 19, 2012.

\*\* The # tested listed for repeaters represent examinations given, not the number of examinees for the specified time period.

--- USMLE does not report percent for cohort populations of five or fewer examinations

Table 4

<b>2012 STEP 3 ADMINISTRATIONS *</b> Number Tested and Percent Passing		
	<b># Tested</b>	<b># Passing</b>
<b>Examinees from US/Canadian Schools that Grant:</b>		
MD Degree	19,056	95%
1st Takers	18,172	96%
Repeaters**	884	69%
DO Degree	16	100%
1st Takers	16	100%
Repeaters**	0	NA
Total US/Canadian	19,072	95%
<b>Examinees from Non-US/Canadian Schools</b>		
1st Takers	8,500	83%
Repeaters**	2,006	56%
Total non-US/Canadian	10,506	78%

Notes for Table 4

\* The table represents data for examinees tested in 2012 with scores reported by February 6, 2013.

\*\* The # tested listed for repeaters represent examinations given, not the number of examinees for the specified time period.

Page intentionally left blank