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MEDICAL EXAMINING BOARD
ROOM 121A, 1400 E. WASHINGTON AVENUE, MADISON WI
CONTACT: TOM RYAN (608) 261-2378
JANUARY 16, 2013

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

MEDICAL EXAMINING BOARD MEETING

8:00 A.M

CALL TO ORDER – ROLL CALL

- A. **Adoption of Agenda (1-4)**
- B. **Approval of Medical Examining Board Minutes of December 12, 2012 (5-14)**
- C. **Election of Officers and Appointment of Panels, Committees, and Liaisons (15-18)**
 - 1) Elect a Chair, Vice Chair, and Secretary
 - 2) Appoint Board Members to Panels, Committees, and Liaison Positions
 - 3) **APPEARANCE – Credentialing Staff** – Meet Credentialing Staff and Discuss Process if Necessary
- D. Secretary Matters
- E. Executive Director Matters
 - 1) Paperless Initiative
 - 2) Discussion and Consideration of Changing Date of April Meeting **(19-20)**
- F. **8:15 A.M. – APPEARANCE – Kim Kluck** – Presentation of Petition for Summary Suspension in Case Number 11 MED 315, Giuditta Angelini, M.D.
- G. Discussion and Consideration of Insurance Company Response to Board Discipline Orders – Sheldon Wasserman **(21-22)**
- H. Administrative/Legislative Rule Matters
 - 1) Wisconsin Administrative Code Chapter MED 8 – Rule Writing Status **(23-24)**
 - 2) Wisconsin Administrative Code Chapter MED 10 – Rule Writing Status **(25-26)**
- I. **Status of Board Consideration of Executive Order #61 (27-34)**

- J. **Discussion and Consideration of Position Statements, ALJ Decision and Position Papers (35-86)**
- K. Discussion and Consideration of ACGME Post Graduate Education Requirement **(87-88)**
- L. **Discussion and Consideration of Duties to Report Professional Misconduct (89-108)**
- M. Report on American Association of Osteopathic Examiners 2013 Summit Meeting, January 4-5, Scottsdale, AZ – Mary Jo Capodice
- N. PDMP Update
- O. FSMB Matters
 - 1) Consider Motions to Appoint Delegate, Alternate Delegate and Travel for appointee and Executive Director to FSMB Annual Meeting, April 18-20, Boston, MA
 - 2) January 2013 FSMB Conference Regarding Portability
 - 3) Other
- P. Items Received After Printing of the Agenda:
 - 1) Presentation of Proposed Stipulation(s), Final Decision(s) and Order(s)
 - 2) Presentation of Proposed Decision(s)
 - 3) Presentation of Interim Order(s)
 - 4) Petitions for Re-Hearing
 - 5) Petitions for Summary Suspension
 - 6) Petitions for Extension of Time
 - 7) Petitions for Assessments
 - 8) Petitions to Vacate Orders
 - 9) Petitions for Designation of Hearing Examiner
 - 10) Requests for Disciplinary Proceeding Presentations
 - 11) Motions
 - 12) Appearances from Requests Received or Renewed
 - 13) Speaking Engagement, Travel, and Public Relation Requests
 - 14) Application Issues
 - 15) Examination Issues
 - 16) Continuing Education Issues
- Q. Screening Panel Report
- R. Informational Item(s)
- S. Public Comment(s)
- T. New/Other Business

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

- U. **11:20 A.M. – APPEARANCE – Omokhuale Omokhodion, M.D - Full Board Oral Examination (109-170)**

- V. **Application Matters**
 - 1) Belmarie P. Roman Maradiaga, M.D. – Request for Board Finding of Accreditation Council for Graduate Medical Education (ACGME) Equivalence **(171-206)**
 - 2) Sajid S. Khan, M.D. – Request for Board Finding of Accreditation Council for Graduate Medical Education (ACGME) Equivalence **(207-250)**

- W. **Deliberation of Proposed Stipulations and Final Decisions and Orders**
 - 1) Paul K. Awa, M.D. (12 MED 132) **(251-256)**
 - 2) Edward J. Muellerleile, M.D. (12 MED 331) **(257-266)**

- X. **Deliberation of Petition for Summary Suspension in Case Number 11 MED 315, Giuditta Angelini, M.D. (267-274)**

- Y. **Complaint for Determination of Probable Cause in Case Number 11 MED 315, Giuditta Angelini, M.D. (275-278)**

- Z. **Order Granting Partial Summary Judgment and Proposed Decision and Order in the Matter of Disciplinary Proceedings Against Graham R. Case, M.D., DHA Case No. SPS-11-0034 DLSC Case No. 08 MED 249 (279-304)**

- AA. **Administrative Warnings**
 - 1) 12 MED 333 – J.E.M. **(305-308)**
 - 2) 12 MED 333 – T.M.M. **(309-312)**

- BB. **Division of Legal Services and Compliance**
 - 1) Case Status Report
 - 2) Case Closings

- CC. **Consulting with Legal Counsel**
 - 1) **12:15 P.M. – APPEARANCE – Legal Counsel** – Planned Parenthood Lawsuit Challenging 2011 Wisconsin Act 217 **(313-318)**

DD. Deliberation of Items Received After Printing of the Agenda:

- 1) Proposed Stipulations
- 2) Proposed Decisions and Orders
- 3) Proposed Interim Orders
- 4) Objections and Responses to Objections
- 5) Complaints
- 6) Petitions for Summary Suspension
- 7) Remedial Education Cases
- 8) Petitions for Extension of Time
- 9) Petitions for Assessments
- 10) Petitions to Vacate Orders
- 11) Motions
- 12) Administrative Warnings
- 13) Matters Relating to Costs
- 14) Appearances from Requests Received or Renewed
- 15) Examination Issues
- 16) Continuing Education Issues
- 17) Application Issues
- 18) Monitoring Cases
- 19) Professional Assistance Procedure Cases

EE. Ratifying Licenses and Certificates

RECONVENE INTO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION

Voting on Items Considered or Deliberated on in Closed Session, If Voting is Appropriate

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

GG. Other Board Business

ADJOURNMENT

NEXT MEDICAL EXAMINING BOARD MEETING: 2/20/2013

2:00 P.M.

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

CLOSED SESSION – Reviewing applications and conducting oral examinations of four (4) candidates for licensure – Drs. Capodice, Erickson, Osborn, and Wasserman

**MEDICAL EXAMINING BOARD
MEETING MINUTES
DECEMBER 12, 2012**

PRESENT: James Barr; Mary Jo Capodice, DO; Sridhar Vasudevan, MD; Kenneth Simons, MD; Gene Musser, MD (*left the meeting at 2:30 p.m.*); Jude Genereaux (*left the meeting at 2:00 p.m.*); Sandra Osborn, MD; Greg Collins; Sheldon Wasserman, MD; Timothy Westlake, MD; Rodney Erickson, MD; Suresh Misra, MD, Timothy Swan, MD

STAFF: Tom Ryan, Executive Director; Matthew Niehaus, Bureau Assistant; and other Department Staff

CALL TO ORDER

Dr. Sheldon Wasserman, Chair, called the meeting to order at 8:04 a.m. A quorum of thirteen (13) members was present.

ADOPTION OF AGENDA

Amendments to the Agenda

- Item “H” (open session) **ADD** the agenda item titled “Review of the Revised FSMB Model Policy on the Appropriate Use of Opioid Analgesics in the Treatment of Pain and Model Policy on Opioid Addiction Treatment in the Medical Office Report by Sri Vasudevan”
- Item “N-13” (open session) **ADD** the agenda item titled “April FSMB Meeting in Dallas Fort Worth”
- Item “V-17” (closed session) **ADD** the agenda item titled “Warren E. Tripp, M.D. (12 MED 315)”
- Item “V-19” (closed session) **ADD** the agenda item titled “Peter S. Jerome (12 MED 341)”
- Item “V-28” (closed session) **ADD** the agenda item titled “Gloria Lopez, M.D. (12 MED 035)”
- Item “V-30” (closed session) **ADD** the agenda item titled “11 MED 217”
- Item “W-4” (closed session) **ADD** the agenda item titled “Daniel T. Cabot, D.O. (11 MED 147)”
- Item “W-5” (closed session) **ADD** the agenda item titled “Vikramjit Chhokar, M.D. (11 MED 400)”

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

APPROVAL OF MINUTES OF NOVEMBER 14, 2012

MOTION: Suresh Misra moved, seconded by, Timothy Westlake to approve the minutes of November 14, 2012 as published. Motion carried.

Gene Musser abstained from voting.

DISCUSSION AND CONSIDERATION OF WIS. ADMIN. CODE RULE WRITING

Patient Abandonment

MOTION: Kenneth Simons moved, seconded by Tim Swan, to amend the language in Wis. Admin. Code MED 10 regarding patient abandonment to:

(O) Patient Abandonment.

Abandonment occurs when an active professional relationship between physician and patient is terminated by the physician and any of the following occur:

- a. The physician fails to give the patient notice at least 30 days in advance of the date on which the physician's withdrawal becomes effective.
- b. The physician fails to allow for patient access or transfer of the patient's health care records as required by law.
- c. If necessary to avoid unacceptable risk of harm, the physician fails to provide for continuity of prescription medications.
- d. The physician fails to provide for emergency care during the period between the notice of intent to withdraw from the physician-patient relationship and the date on which the physician-patient relationship ends.

Motion carried.

Three nay votes were made.

MOTION: Sridhar Vasudevan moved, seconded by Sandra Osborn, to approve Chapter 10 as amended. Motion carried unanimously.

DISCUSSION AND CONSIDERATION OF JANUARY 16-17, 2013 ONE DAY CONFERENCE IN FORT WORTH

MOTION: Gene Musser moved, seconded by Suresh Misra, to send Tom Ryan to the January 16-17, 2013 FSMB conference in Fort Worth and to designate Timothy Swan, or designees determined by the chair, as the Board's representative to attend this meeting. Motion carried.

DISCUSSION AND CONSIDERATION OF STATE BOARD SPONSORSHIP ROLE IN STEP 3 REGARDING POSSIBLE INPUT BACK TO THE FEDERATION OF STATE MEDICAL BOARDS

MOTION: Kenneth Simons moved, seconded by Sridhar Vasudevan, that the Board recommends that USMLE Step 3 no longer be state sponsored and that the FSMB and NBME create a policy regarding eligibility requirements relating to the number of months of post-graduate training required before one can sit for the USMLE Step 3. Motion carried.

SCREENING PANEL REPORT

Jude Genereaux reported thirty-four (34) cases were screened. Eight (8) cases were opened.

CLOSED SESSION

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

The Board convened into Closed Session at 10:25 a.m.

FULL BOARD ORAL EXAMINATION

*Robert S. Shulman, M.D. appeared before the Board at 11:24 a.m.
Timothy Swan left the room at 11:24 a.m.*

MOTION: Sridhar Vasudevan moved, seconded by Sandra Osborn, to pass Robert S. Shulman, M.D.'s full board oral examination. Motion carried.
4 nay votes were made.

MOTION: Sandra Osborn moved, seconded by Gene Musser, to deny Robert S. Shulman, M.D.'s request for full licensure. The Board grants Applicant a limited license requiring Applicant to complete a Board-approved psychiatric review course, including any testing components, prior to resuming practice. After completion of the psychiatric review course and presentation to the Chair of successful completion, pending the Chair's approval, Applicant will be granted full licensure. Motion carried.
Sridhar Vasudevan voted nay.

APPLICATION MATTERS

MOTION: Suresh Misra moved, seconded by Jude Genereaux, to find that Shadi A Al Ekish, M.D.'s post-graduate training is not equivalent to a year of ACGME accredited training, and denies Applicant's request. **Reason for Denial:** The Board does not find Applicant's training to be equivalent to ACGME accredited training. Motion carried.
Two nay votes and one abstention were made.

DELIBERATION ON MONITORING MATTERS

Timothy Swan returned to the room at 12:09 p.m.

Suresh Misra left the room at 12:10 p.m.

David “Corey” Hanes, D.O. appeared before the Board at 12:11 p.m.

Suresh Misra returned to the room at 12:15 p.m.

David “Corey” Hanes, D.O. – Removal of Limitation/Grant Full Licensure

MOTION: Kenneth Simons moved, seconded by Timothy Swan, to grant the request of David “Corey” Hanes, D.O. for removal of limitation and grant full licensure. Motion carried unanimously.

Anatol J. Stankevych, M.D. appeared before the Board at 12:20 p.m.

Anatol J. Stankevych, M.D. – Removal of Limitation

MOTION: Sandra Osborn moved, seconded by Suresh Misra, to deny the request of Anatol J. Stankevych, M.D., for removal of limitations. **Reason for Denial:** The Board does not believe that he is capable of minimally competent practice based on his hand injury. Motion carried unanimously.

Giuditta Angelini, M.D. – Consideration of Noncompliance with Board Order

MOTION: Sandra Osborn moved, seconded by Suresh Misra, to refer Giuditta Angelini, M.D. to DLSC for violation of Board Order and, if appropriate, a summary suspension proceeding. Motion carried unanimously.

Roman Berezovski, M.D. – Requesting Reduction in Drug Screens and Removal of Limitation

MOTION: Sridhar Vasudevan moved, seconded by Suresh Misra, to grant the request of Roman Berezovski, M.D., for reduction in the frequency of drug screens to no less than thirty-six (36) per year with one (1) annual hair test. Motion carried unanimously.

MOTION: Timothy Swan moved, seconded by Kenneth Simons, to deny the request of Roman Berezovski, M.D., for removal of limitations. Motion carried unanimously.

Shirley Y. Godiwalla, M.D. – Requesting Approval for Training Program

MOTION: Sandra Osborn moved, seconded by Suresh Misra, to grant the request of Shirley Y. Godiwalla, M.D., for approval for her two-year training program in Pediatric Urology at the University of Oklahoma. Motion carried unanimously.

Sridhar Vasudevan recused himself from voting in the matter of Shirley Y. Godiwalla, M.D.

Stefan J. Konasiewicz, M.D. – Requesting Termination of Encumbrances and Conditions

MOTION: Tim Swan moved, seconded by Gene Musser, to acknowledge that they have received sufficient proof that all limitations have been removed from Stefan J. Konasiewicz, M.D.'s Minnesota license. The Board removes the limitations and conditions from his Wisconsin license. Motion carried unanimously.

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

MOTION: Sridhar Vasudevan moved, seconded by Jude Genereaux, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Orders in the disciplinary proceedings against Tilok Ghose, M.D. (12 MED 273.) Motion carried unanimously.

MOTION: Suresh Misra moved, seconded by Kenneth Simons, to issue an administrative warning in the matter of 12 MED 074. Motion carried unanimously.

MOTION: Kenneth Simons moved, seconded by Tim Westlake, to issue an administrative warning in the matter of 12 MED 252. Motion carried unanimously.

MOTION: Jude Genereaux moved, seconded by Sridhar Vasudevan, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Orders in the disciplinary proceedings against Susan J Carson, M.D. (12 MED 008.) Motion carried unanimously.

Gene Musser abstained from voting on the matter of Susan J. Carson, M.D. (12 MED 008)

MOTION: Jude Genereaux moved, seconded by Sridhar Vasudevan, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Orders in the disciplinary proceedings against Jennifer Y. Edgoose, M.D. (12 MED 011.) Motion carried unanimously.

Gene Musser abstained from voting on the matter of Jennifer Y. Edgoose, M.D. (12 MED 011)

MOTION: Jude Genereaux moved, seconded by Sridhar Vasudevan, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Orders in the disciplinary proceedings against Laurel B. Mark, M.D. (12 MED 012.) Motion carried unanimously.

Gene Musser abstained from voting on the matter of Laurel B. Mark, M.D. (12 MED 012)

MOTION: Jude Genereaux moved, seconded by Sridhar Vasudevan, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Orders in the disciplinary proceedings against Dipesh Navsaria, M.D. (12 MED 013.) Motion carried unanimously.

Gene Musser abstained from voting on the matter of Dipseh Navsaria, M.D. (12 MED 013)

MOTION: Sridhar Vasudevan moved, seconded by Jude Genereaux, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Orders in the disciplinary proceedings against Richard G. Schmelzer, M.D. (12 MED 015.) Motion carried unanimously.

Gene Musser abstained from voting on the matter of Richard G. Schmelzer, M.D. (12 MED 015)

MOTION: Jude Genereaux moved, seconded by Sridhar Vasudevan, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Orders in the disciplinary proceedings against Melissa M. Stiles, M.D. (12 MED 017.) Motion carried unanimously.

Gene Musser abstained from voting on the matter of Melissa M. Stiles, M.D. (12 MED 017)

MOTION: Kenneth Simons moved, seconded by Sandra Osborn, to issue an administrative warning in the matter of 12 MED 007. Motion carried unanimously.

Gene Musser abstained from voting on the matter of (12 MED 007)

MOTION: Kenneth Simons moved, seconded by Sandra Osborn, to issue an administrative warning in the matter of 12 MED 009. Motion carried unanimously.

Gene Musser abstained from voting on the matter of (12 MED 009)

MOTION: Kenneth Simons moved, seconded by Sandra Osborn, to issue an administrative warning in the matter of 12 MED 010. Motion carried unanimously.

Gene Musser abstained from voting on the matter of (12 MED 010)

MOTION: Kenneth Simons moved, seconded by Sandra Osborn, to issue an administrative warning in the matter of 12 MED 014. Motion carried unanimously.

Gene Musser abstained from voting on the matter of (12 MED 014)

MOTION: Kenneth Simons moved, seconded by Sandra Osborn, to issue an administrative warning in the matter of 12 MED 016. Motion carried unanimously.

Gene Musser abstained from voting on the matter of (12 MED 016)

Jude Genereaux left the meeting at 2:00 p.m.

MOTION: Kenneth Simons moved, seconded by Tim Westlake, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Orders in the disciplinary

proceedings against Sean M. Cashin, M.D. (11 MED 301.) Motion carried unanimously.

MOTION: Sandra Osborn moved, seconded by Gene Musser, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Orders in the disciplinary proceedings against Heath J. Meyer, M.D. (12 MED 281.) Motion carried unanimously.

Sridhar Vasudevan left the room at 2:09 p.m.

MOTION: Kenneth Simons moved, seconded by Suresh Misra, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Orders in the disciplinary proceedings against Floyd O. Anderson, M.D. (12 MED 359.) Motion carried unanimously.

MOTION: Gene Musser moved, seconded by Suresh Misra, to issue an administrative warning in the matter of 12 MED 121. Motion carried unanimously.

MOTION: Gene Musser moved, seconded by Kenneth Simons, to issue an administrative warning in the matter of 12 MED 286. Motion carried unanimously.

Sridhar Vasudevan entered the meeting at 2:10 p.m.

MOTION: Kenneth Simons moved, seconded by Suresh Misra, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Orders for remedial education against Warren E. Tripp, M.D. (12 MED 315.) Motion carried unanimously.

MOTION: Timothy Swan moved, seconded by Gene Musser, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Orders in the disciplinary proceedings against Peter S. Jerome, (12 MED 341.) Motion carried unanimously.

MOTION: Kenneth Simons moved, seconded by Gene Musser, to issue an administrative warning in the matter of 12 MED 326. Motion carried unanimously.

MOTION: Timothy Swan moved, seconded by Sandra Osborn, to issue an administrative warning in the matter of 12 MED 358. Motion carried unanimously.

Sheldon Wasserman left the meeting at 2:24 p.m.

Sheldon Wasserman returned to the meeting at 2:29 p.m.

Gene Musser left the meeting at 2:30 p.m.

MOTION: Sridhar Vasudevan moved, seconded by Suresh Misra, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Orders in the disciplinary proceedings against Hans P. Schlecht, D.O. (11 MED 247.) Motion carried unanimously.

MOTION: Kenneth Simons moved, seconded by Sandra Osborn, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Orders in the disciplinary proceedings against Michael C. Macatol, M.D. (11 MED 277.) Motion carried unanimously.

MOTION: Timothy Swan moved, seconded by Kenneth Simons, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Orders in the disciplinary proceedings against Peter Barbian, M.D. (11 MED 371.) Motion carried unanimously.

MOTION: Sandra Osborn moved, seconded by Suresh Misra, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Orders in the disciplinary proceedings against Sami A. Roumani, M.D. (12 MED 035.) Motion carried unanimously.

MOTION: James Barr moved, seconded by Greg Collins, to adopt the Findings of Fact, Conclusions of Law, Final Decision and Orders in the disciplinary proceedings against Gloria Lopez, M.D. (12 MED 067.) Motion carried unanimously.

MOTION: Sridhar Vasudevan moved, seconded by Suresh Misra, to issue an administrative warning in the matter of 11 MED 333. Motion carried unanimously.

MOTION: Mary Jo Capodice moved, seconded by Sandra Osborn, to issue an administrative warning in the matter of 11 MED 217. Motion carried unanimously.

COMPLAINT FOR DETERMINATION OF PROBABLE CAUSE

Greg Collins left the room at 2:35 p.m.

MOTION: Sridhar Vasudevan moved, seconded by Suresh Misra, to find probable cause to issue a complaint in the matter of Peri Aldrich, M.D. (12 MED 140.) Motion carried unanimously.

MOTION: Kenneth Simons moved, seconded by Suresh Misra, to find probable cause to issue a complaint in the matter of John W. Zwiacher, M.D. (12 MED 187.) Motion carried unanimously.

Greg Collins returned to the room at 2:37 p.m.

MOTION: Sridhar Vasudevan moved, seconded by Tim Swan, to find probable cause to issue a complaint in the matter of Daniel T. Cabot, D.O. (11 MED 147.) Motion carried unanimously.

Rodney Erickson was not in the room for deliberation or voting in the matter of Daniel T. Cabot, D.O. (11 MED 147.)

MOTION: Kenneth Simons moved, seconded by Greg Collins, to find probable cause to issue a complaint in the matter of Vikramjit Chhokar, M.D. (11 MED 400.) Motion carried unanimously.

Gene Musser was not in the room for deliberation or voting in the matter of Vikramjit Chhokar, M.D. (11 MED 400.)

CASE CLOSINGS

MOTION: Sridhar Vasudevan moved, seconded by Suresh Misra, to close the case #12 MED 117 for No Violation (NV). Motion carried unanimously.

MOTION: Jude Genereaux moved, seconded by Suresh Misra, to close the case #12 MED 230 for Prosecutorial Discretion (P3). Motion carried.
Two nay votes were made.

MOTION: Tim Swan moved, seconded by Sandra Osborn, to close the case #12 MED 320 for No Violation (NV). Motion carried unanimously.

MOTION: Suresh Misra moved, seconded by Sandra Osborn, to close the case #12 MED 255 for No Violation (NV). Motion carried unanimously.

RATIFY ALL LICENSES AND CERTIFICATES

MOTION: Kenneth Simons moved, seconded by Suresh Misra, to ratify all licenses and certificates as issued. Motion carried unanimously.

RECONVENE TO OPEN SESSION

MOTION: Kenneth Simons moved, seconded by Tim Westlake, to reconvene into open session. Motion carried unanimously.

The Board reconvened into Open Session at 2:48 p.m.

VOTING ON ITEMS CONSIDERED OR DELIBERATED ON IN CLOSED SESSION

MOTION: Kenneth Simons moved, seconded by Tim Swan, to affirm all motions made in closed session. Motion carried unanimously.

ADJOURNMENT

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

The meeting adjourned at 2:50 p.m.

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:	
Items will be considered late if submitted after 4:30 p.m. and less than: ■ 10 work days before the meeting for Medical Board ■ 14 work days before the meeting for all others			
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: January 16, 2013	5) Attachments: x Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Election of Officers and Appointment of Panels, Committees and Liaisons	
7) Place Item in: x Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <u>Yes</u> - Division of Credential Processing Staff will appear during appointment of Credentialing Liaisons	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: 1) Elect a Chair, Vice Chair and Secretary 2) Appoint Board members to panels, committees and liaison positions 3) Meet Credentialing Staff and discuss process if necessary			
11) Authorization			
Signature of person making this request			Date
Supervisor (if required)			Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date

Officers- §§ 15.07(2), 15.08(2)

Approved by Board: [DATE]

Chair:

Vice-Chair:

Secretary:

Panels & Committees

Name of Panel / Committee	Description	Nomination Date - Member
Screening Panel	Reviews complaints received by the Department to determine whether a case should be opened for investigation. Panel members, consisting of two professional members and one public member, alternate monthly.	Department sets the schedule after seeking input from Board members for the periods January – June and July – December, in advance.

Liaisons

Various matters arise in the Department that necessitate a quick decision by the board. In these cases, having a board member to serve as the liaison to the Department can expedite action and prevent unnecessary delays that would result from waiting until the next meeting. Board liaisons should give a report to the full board at the next meeting describing what actions were taken. Given that no individual board member may act on behalf of the board without specific authority to do so, each board must specifically delegate authority to each liaison by motion.

Liaison	Duties	Name of Board Member as of 1/13	Date of Motion Delegating Authority
Legal Services and Compliance Liaison	Make decisions on routine questions involving disciplinary and monitoring matters.	Division Liaison – Sandra Osborn Professional Assistance Procedure (PAP) Liaison: Sandra Osborn; first alternate – Sheldon Wasserman; second alternate – Mary Jo Capodice	
Office of Education and Exams Liaison	Make decisions on routine questions involving the administration of examinations and approval of education programs.	None	
Website Liaison	Make decisions about board materials posted to the DSPS website.	None	
Credentialing Liaisons (3):	Consult with Department staff on the processing of applications.	Suresh Misra, Ken Simons, Sheldon Wasserman	
Legislative Liaison(s)	Track legislation and report on activity to the Board and Department Policy Manger.	Suresh Misra, Gene Musser, Ken Simons, Sheldon Wasserman	
Maintenance of Licensure (MOL)	Track MOL, make reports and recommendations to the full Board for full Board consideration.	Rodney Erickson	
Newsletter Liaison	Recommend article ideas to the Board, assign Board members to write articles, review drafts of Digest.	Jude Genereaux	

Wis. Admin. Code Chapter MED 8	Review and revise rule drafts, report and make recommendations to full Board for full Board consideration.	Gene Musser	
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General Delegation Motion:

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

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Ken Simons		2) Date When Request Submitted: <div style="border: 1px solid black; padding: 2px; font-size: small;"> Items will be considered late if submitted after 4:30 p.m. and less than: ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others </div>	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: January 16, 2013	5) Attachments: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6) How should the item be titled on the agenda page? Date of April meeting	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? 	9) Name of Case Advisor(s), if required: 	
10) Describe the issue and action that should be addressed: Dr. Simons has requested that the April meeting date be reconsidered. It is currently scheduled for Wednesday, April 17. The FSMB meeting begins on Thursday, April 18. Board members attending the meeting may need to miss part of the meeting due to flight conflicts.			
11) Authorization			
Signature of person making this request			Date
Supervisor (if required)			Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Sheldon Wasserman		2) Date When Request Submitted: <div style="border: 1px solid black; padding: 2px; font-size: small;"> Items will be considered late if submitted after 4:30 p.m. and less than: ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others </div>	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: January 16, 2013	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Insurance Company Response to Board Discipline Orders	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? 	9) Name of Case Advisor(s), if required: 	
10) Describe the issue and action that should be addressed: Dr. Wasserman will lead this discussion.			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Gene Musser		2) Date When Request Submitted: <div style="border: 1px solid black; padding: 2px; font-size: small;"> Items will be considered late if submitted after 4:30 p.m. and less than: ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others </div>	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: January 16, 2013	5) Attachments: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6) How should the item be titled on the agenda page? Wisconsin Administrative Code Chapter MED 8 – Rule writing status	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? 	9) Name of Case Advisor(s), if required: 	
10) Describe the issue and action that should be addressed: Gene Musser will advise the Board on the status of the pending rule changes.			
11) Authorization			
Signature of person making this request			Date
Supervisor (if required)			Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date

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

AGENDA REQUEST FORM

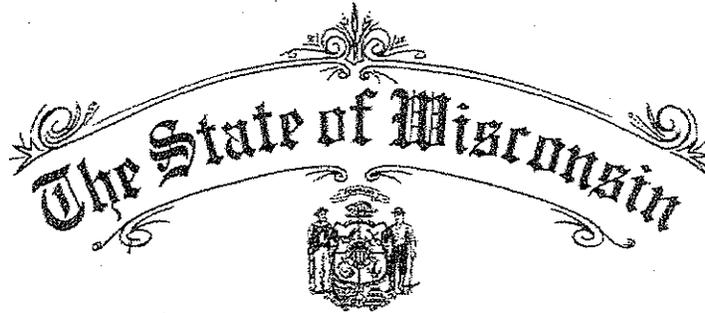
1) Name and Title of Person Submitting the Request: Sheldon Wasserman		2) Date When Request Submitted: <div style="border: 1px solid black; padding: 2px;">Items will be considered late if submitted after 4:30 p.m. and less than: ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others</div>	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: January 16, 2013	5) Attachments: Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Wisconsin Administrative Code Chapter MED 10 – Rule writing status	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? Yes. Shawn Leatherwood, Advanced Paralegal, Division of Policy Development	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Shawn Leatherwood will advise the Board on the status of the pending rule changes.			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Office of the Governor		2) Date When Request Submitted: Items will be considered late if submitted after 4:30 p.m. and less than: ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: January 16, 2013	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Executive Order #61	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing?	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: To comply with Executive Order #61, the Board is being asked to review its rules to identify rules that unnecessarily burden small businesses to conduct their affairs and expand. The following options are suggested for undertaking this assignment, with a report back to the Board at its next meeting: <ol style="list-style-type: none"> 1. Appoint a member of the Board to review the rules; 2. Divide the rules among Board members for review; 3. All Board members could review the rules individually. If the Board decides at the next meeting that there is a need to write rules, the next step would be to draft a scope statement.			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	



OFFICE OF THE GOVERNOR

EXECUTIVE ORDER # 61

Relating to Job Creation and Small Business Expansion

WHEREAS, creating jobs and growing our state's economy is dependent on a vibrant small business sector; and

WHEREAS, small businesses have generated 64% of net new jobs over the past fifteen years and employ over half of all private sector employees; and

WHEREAS, according to recent U.S. Census data, 86% of Wisconsin business employ fewer than 20 workers, and 74% have ten workers or less; and

WHEREAS, small businesses spend 80% more per worker than large employers to comply with government regulations and, according to a recent National Federation of Independent Business survey of Wisconsin employers, 91% said it was impossible to know about, comply with, and understand all of government's regulations; and

WHEREAS, according to the U.S. Small Business Administration, complying with government regulations costs small businesses \$10,585 per worker, which discourages investment and hiring by small businesses; and

WHEREAS, government regulations are regularly cited as one of the top three concerns for small business growth, according to NFIB's Small Business Optimism Index; and

WHEREAS, 2011 Wisconsin Act 46 strengthened Wisconsin's Small Business Regulatory Review Board (Board) empowering small business owners and giving them the ability to judge the economic impact of government regulation; and

WHEREAS, 2011 Wisconsin Act 46 requires state agencies to submit any rule with an economic impact to the Board for review and allows the Board to suggest changes to the agency that will improve compliance and reduce the rule's burden on small businesses; and

WHEREAS, pursuant to Wis. Stat. § 227.30, the Board has the authority to review rules and guidelines of any agency to determine whether any of those rules or guidelines place an unnecessary burden on the ability of small businesses to conduct their affairs; and

WHEREAS, state agencies and the Board should not only be reviewing new rules but collaborating to reform existing rules that hinder job creation and small business expansion and that this effort would help further the state's goal of creating 250,000 jobs by 2015.

NOW THEREFORE, I, SCOTT WALKER, Governor of the State of Wisconsin, by the authority vested in me by the Constitution and laws of this State, specifically Wis. Stat. § 227.10(2m), do hereby:

1. Require all state agencies to review 2011 Wisconsin Act 46 to ensure they are in compliance, ready to assist small business owners, and properly submitting any proposed rules with an economic impact to the Board;
2. Require all state agencies to cooperate with the Board to identify existing rules hindering job creation and small business growth;

3. Require all state agencies to work with the Board to recommend changes to these rules that will both reduce their burden on job creators while continuing to comply with the intent of the statutes that created them;
4. Require all state agencies to work with the Board to identify strategies that will increase compliance with existing rules;
5. Request that the Board engage small business owners and their representative organizations to gather input on any rules hindering job growth;
6. Request that the Board provide a report and analysis of these rules, in a manner similar to Wis. Stat. § 227.30(1), to the Governor's Office of Regulatory Compliance and the agency with the authority to amend the rules, which details the rules they have identified for modification.



IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Wisconsin to be affixed. Done in the City of Eau Claire this twenty-second day of February, in the year two thousand twelve.


SCOTT WALKER
Governor

By the Governor:


DOUGLAS LA FOLLETTE
Secretary of State

notice, under ch. 985, of the hearing in the official state newspaper and give any other notice which the committee directs. The hearing shall be conducted in accordance with s. 227.18 and shall be held not more than 60 days after receipt of notice of the requirement.

History: 1985 a. 182 ss. 1, 3, 50; 1987 a. 186; 2005 a. 249.

Rule suspension under sub. (2) (d) does not violate the separation of powers doctrine. *Martinez v. DILHR*, 165 Wis. 2d 687, 478 N.W.2d 582 (1992).

A collective bargaining agreement between the regents and the teaching assistants association is not subject to review by the committee. 59 Atty. Gen. 200.

In giving notice of public hearings held under sub. (2), the committee should concurrently employ the various forms of notice available that best fit the particular circumstances. 62 Atty. Gen. 299.

If an administrative rule is properly adopted and is within the power of the legislature to delegate there is no material difference between it and a law. No law, including a valid rule can be revoked by a joint resolution of the legislature as such a resolution deprives the executive its power to veto an act of the legislature. 63 Atty. Gen. 159.

Legislative committee review of administrative rules in Wisconsin. Bunn and Gallagher. 1977 WLR 935.

227.27 Construction of administrative rules.

- (1) In construing rules, ss. 990.001, 990.01, 990.03 (1), (2) and (4), 990.04 and 990.06 apply in the same manner in which they apply to statutes, except that ss. 990.001 and 990.01 do not apply if the construction would produce a result that is inconsistent with the manifest intent of the agency.
- (2) The code shall be prima facie evidence in all courts and proceedings as provided by s. 889.01, but this does not preclude reference to or, in case of a discrepancy, control over a rule filed with the legislative reference bureau or the secretary of state, and the certified copy of a rule shall also and in the same degree be prima facie evidence in all courts and proceedings.

History: 1983 a. 544; 1985 a. 182 ss. 22, 55 (2), (3); Stats. 1985 s. 227.27; 2005 a. 249; 2007 a. 20.

227.30 Review of administrative rules or guidelines.

- (1) The small business regulatory review board may review the rules and guidelines of any agency to determine whether any of those rules or guidelines place an unnecessary burden on the ability of small businesses, as defined in s. 227.114 (1), to conduct their affairs. If the board determines that a rule or guideline places an unnecessary burden on the ability of a small business to conduct its affairs, the board shall submit a report and recommendations regarding the rule or guideline to the joint committee for review of administrative rules and to the agency.
- (2) When reviewing the report, the joint committee for review of administrative rules shall consider all of the following:
 - (a) The continued need for the rule or guideline.
 - (b) The nature of the complaints and comments received from the public regarding the rule or guideline.
 - (c) The complexity of the rule or guideline.

- (d) The extent to which the rule or guideline overlaps, duplicates, or conflicts with federal regulations, other state rules, or local ordinances.
 - (e) The length of time since the rule or guideline has been evaluated.
 - (f) The degree to which technology, economic conditions, or other factors have changed in the subject area affected by the rule or guideline since the rule or guideline was promulgated.
- (3) The joint committee for review of administrative rules may refer the report regarding the rule or guideline to the presiding officer of each house of the legislature for referral to a committee under s. 227.19 (2) or may review the rule or guideline as provided under s. 227.26.

History: 2003 a. 145; 2005 a. 249.

SUBCHAPTER III

ADMINISTRATIVE ACTIONS AND JUDICIAL REVIEW

Cross-reference: See also ch. NR 2, Wis. adm. code.

227.40 Declaratory judgment proceedings.

- (1) Except as provided in sub. (2), the exclusive means of judicial review of the validity of a rule shall be an action for declaratory judgment as to the validity of the rule brought in the circuit court for the county where the party asserting the invalidity of the rule resides or has its principal place of business or, if that party is a nonresident or does not have its principal place of business in this state, in the circuit court for the county where the dispute arose. The officer or other agency whose rule is involved shall be the party defendant. The summons in the action shall be served as provided in s. 801.11 (3) and by delivering a copy to that officer or, if the agency is composed of more than one person, to the secretary or clerk of the agency or to any member of the agency. The court shall render a declaratory judgment in the action only when it appears from the complaint and the supporting evidence that the rule or its threatened application interferes with or impairs, or threatens to interfere with or impair, the legal rights and privileges of the plaintiff. A declaratory judgment may be rendered whether or not the plaintiff has first requested the agency to pass upon the validity of the rule in question.
- (2) The validity of a rule may be determined in any of the following judicial proceedings when material therein:
 - (a) Any civil proceeding by the state or any officer or agency thereof to enforce a statute or to recover thereunder, provided such proceeding is not based upon a matter as to which the opposing party is accorded an administrative review or a judicial review by other provisions of the statutes and such opposing party has failed to exercise such right to review so accorded;
 - (b) Criminal prosecutions;
 - (c) Proceedings or prosecutions for violations of county or municipal ordinances;
 - (d) Habeas corpus proceedings relating to criminal prosecution;

**227.10 Statements of policy and interpretations of law;
discrimination prohibited.**

- (1)** Each agency shall promulgate as a rule each statement of general policy and each interpretation of a statute which it specifically adopts to govern its enforcement or administration of that statute. A statement of policy or an interpretation of a statute made in the decision of a contested case, in a private letter ruling under s. 73.035 or in an agency decision upon or disposition of a particular matter as applied to a specific set of facts does not render it a rule or constitute specific adoption of a rule and is not required to be promulgated as a rule.
- (2)** No agency may promulgate a rule which conflicts with state law.
- (2m)** No agency may implement or enforce any standard, requirement, or threshold, including as a term or condition of any license issued by the agency, unless that standard, requirement, or threshold is explicitly required or explicitly permitted by statute or by a rule that has been promulgated in accordance with this subchapter. The governor, by executive order, may prescribe guidelines to ensure that rules are promulgated in compliance with this subchapter.

227.114 Rule making; considerations for small business.

227.114(2)

- (1) In this section, "small business" means a business entity, including its affiliates, which is independently owned and operated and not dominant in its field, and which employs 25 or fewer full-time employees or which has gross annual sales of less than \$5,000,000.
- (2) When an agency proposes or revises a rule that may have an effect on small businesses, the agency shall consider each of the following methods for reducing the impact of the rule on small businesses:
 - (a) The establishment of less stringent compliance or reporting requirements for small businesses.
 - (b) The establishment of less stringent schedules or deadlines for compliance or reporting requirements for small businesses.
 - (c) The consolidation or simplification of compliance or reporting requirements for small businesses.
 - (d) The establishment of performance standards for small businesses to replace design or operational standards required in the rule.
 - (e) The exemption of small businesses from any or all requirements of the rule.

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:	
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: January 16, 2013	5) Attachments: x Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Board Review of Position Statements, ALJ Decision and Position Papers	
7) Place Item in: x Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing?	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: All Boards will be reviewing position statements, position papers and other website content to ensure they are not outdated and comply with statutes, rules and Executive Order 50, relating to guidelines for the promulgation of administrative rules. The following options are suggested for undertaking this assignment, with a report back to the Board at the next meeting: <ol style="list-style-type: none"> 1. Appoint a member of the Board to review the position statements, ALJ decision and position papers; 2. Divide the position statements, ALJ decision and position papers; 3. All Board members could review the the statements, ALJ decision and position papers individually. 			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	



STATE OF WISCONSIN

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

Mail to:
PO Box 8935
Madison WI 53708-8935

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

Governor Scott Walker Secretary Dave Ross

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

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

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

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

As explained below, the supervising physician:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARE SILICONE INJECTIONS LEGAL IN WI?

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

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

MAY A PHYSICIAN DELEGATE DISPENSE SAMPLE MEDICATIONS TO A PATIENT?

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

WHERE MAY ONE FIND GUIDANCE ON PHYSICIAN DISPENSING OF MEDICATIONS?

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

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

DOES WISCONSIN RECOGNIZE NATUROPATHIC DOCTORS?

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

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

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

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

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

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

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

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

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

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

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

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF A PETITION FOR
DECLARATORY RULING INVOLVING

WISCONSIN SOCIETY OF
ANESTHESIOLOGISTS,
PETITIONER,

and

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

LS0511012MED

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

INTERESTED PARTIES.

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

ORDER

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

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

Dated this 15th day of August, 2007.

Gene Musser MD
Member of the Board
Medical Examining Board

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

In the Matter of a Petition for
Declaratory Ruling involving,

WISCONSIN SOCIETY OF
ANESTHESIOLOGISTS,

PETITIONER,

and

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

Case No. LS0511012MED

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

INTERESTED PARTIES.

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

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INTRODUCTION

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

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

DECISION SUMMARY

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

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

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

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

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

PROCEDURAL HISTORY

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

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

PETITION FOR DECLARATORY RULING

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

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

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

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

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

MOTION FOR SUMMARY JUDGMENT

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

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

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

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

BOARD RESPONSIBILITIES AND STRUCTURE

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

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

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

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

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

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

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

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

FINDINGS OF FACT – ADMINISTRATION OF ANESTHESIA

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

LICENSE REQUIRED TO PRACTICE MEDICINE AND SURGERY

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

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

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

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

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

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

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

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

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

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

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

ISSUE PRESENTED

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

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

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

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

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

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

N 8.02 Definitions. As used in this chapter:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE SCOPE OF PROFESSIONAL NURSING AND CRNA PRACTICE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RELATED LAWS

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

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

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

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

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

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

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

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

3. If anesthetics are not administered by a qualified anesthesiologist, they shall be administered by a physician anesthetist, dental anesthetist, podiatrist or a registered nurse anesthetist, under supervision as defined by medical staff policy. The hospital, on recommendation of the medical staff, shall designate persons qualified to administer anesthetics and shall determine what each person is qualified to do.

4. The services provided by podiatrist, dentist or nurse anesthetists shall be documented, as well as the supervision that each receives.

5. If a general anesthetic is used and a physician is not a member of the operating team, a physician shall be immediately available in the hospital or an adjacent clinic to assist in emergency situations. [61]

These rules not only support the conclusion that CRNAs are involved in administration of anesthesia in hospitals, but are structured to permit a CRNA/APNP to practice without physician supervision. Under sub. 5. of these rules, a CRNA may administer anesthesia even if a physician is not a member of the operating team if the medical staff designates the CRNA as qualified. The record includes an affidavit of Irene Temple, an attorney employed by the DHFS, who has responsibility to advise the Department's Bureau of Quality Assurance regarding the interpretation of the Department's rules relating to the regulation of hospitals. With respect to supervision, Irene Temple's affidavit includes the statement that,

Section HFS 124(3) does not specify the extent of supervision of anesthetists who are not anesthesiologists. Under the rule, the extent of supervision required, if any, is to be determined by the hospital through its medical staff policies.

These rules identify a CRNA as a provider of anesthesia service in a hospital and authorize assignment of substantial responsibility to the CRNA.

LIMITATIONS ON PODIATRISTS

Under Wis. Stat. § 448.60(4) "Podiatry" or "podiatric medicine and surgery" is defined to mean,

... that branch or system of the practice of medicine and surgery that involves treating the sick which is limited to conditions affecting the foot and ankle, but does not include the use of a general anesthetic unless administered by or under the direction of a person licensed to practice medicine and surgery under subch. II.

Through an affidavit of its chairperson, Dr. Lisa Reinicke, the PACB stated its position that CRNAs routinely administer general anesthesia to podiatric surgical patients without the supervision of a physician, especially in rural hospitals.

According to Dr. Reinicke, requiring CRNAs to be supervised by a physician would likely impinge upon patient access to podiatric surgical care.

As described above, a CRNA/APNP within an exception to the physician licensing statute. The statute regulating podiatrists contains a similar exception. Under Wis. Stat. § 448.62(1) the statute requiring a podiatry license does not apply to “[a] person lawfully practicing within the scope of a license, permit, registration or certification granted by this state or the federal government.” Consequently, the statutory definition of podiatry does not restrict the lawful practice of a CRNA/APNP.

Rules of the BON mandate that a CRNA/APNP work in a collaborative relationship with a physician. Apart from the required collaborative relationship, a CRNA/APNP practices independently, not under delegated authority from a physician or podiatrist. Of course, both the podiatrist and the CRNA/APNP are required to comply with the appropriate rules of the DHFS governing surgical and anesthesia services which may require that a physician be present or immediately available. For CRNAs not APNP certified, compliance with Wis. Stat. § 448.03(1) requires that the administration of anesthesia by the CRNA be directed, supervised and inspected by a physician who has the power to direct, decide and oversee the patient services. Use of CRNAs to administer general anesthesia appears to be a matter of joint interest between the MEB and the PACB that may warrant discussion under the procedure in Wis. Stat. § 15.085(3)(b)[62].

CONCLUSION

While material facts relating to the administration of anesthesia are generally agreed to by the parties, Petitioner WSA has not shown that it is entitled to judgment on its motion as a matter of law. The conclusions of law proposed by the petitioner relating to physician supervision when a CRNA administers anesthesia are not fully consistent with established state law. There is an overlap in the health care practice of physicians and CRNAs. The law that requires a license as a physician to practice medicine and surgery exempts persons lawfully practicing within the scope of a certificate to practice professional nursing issued by the BON. Administration of anesthesia is included within the statutory definition of “professional nursing.” A CRNA may lawfully administer anesthesia without physician supervision under the exemption if certified as an APNP and if the CRNA maintains and documents a collaborative relationship with a physician.

A CRNA who is not certified as an APNP is not subject to the BON rule requiring a collaborative relationship with a physician and does not qualify for the same exemption from the physician licensing requirement as a CRNA/APNP. Longstanding policies and administrative rules of the BON require physician supervision of administration of anesthesia by a CRNA who is not certified as an APNP.

The appropriate order is to deny petitioners motion for summary judgment.

The proposed order also dismisses the Petition for a Declaratory Ruling because the Medical Board’s decision on Petitioner’s summary judgment motion resolves the controversies presented by the petition. The issues raised by the Petition are essentially questions of law. Additional facts developed from a contested hearing would not change the legal analysis of the central issues. None of the parties has a right to a declaratory ruling. There is no necessity for a declaratory ruling to permit physicians and CRNAs to avoid unprofessional conduct or malpractice findings as was contended by the WSA. Hospitals and insurers may rely on Wis. Stat. chs. 441 and 448 and BON rules to accept the legitimacy of anesthesia administration by CRNA/APNPs working in a collaborative relationship with a physician.

Citing Act 138 and *Sermchief v. Gonzales*, 660 S.W.2d 683 (Mo. 1983), the BON and the WANA argue that the practice of professional nursing has evolved because of changes in healthcare technology, delivery systems, education and training. They contend that the delivery of health care is now provided by a team of professionals who work interdependently in collaborative relationships rather than traditional hierarchical or supervisory models. Although there is a background of change in Wisconsin law relating to the scope of professional nursing consistent with a *Sermchief* type of analysis, the petition in this case presents an issue that is determined directly by reference to statute and administrative rule.

The Medical Examining Board or the Board of Nursing may determine that the petition has raised public policy issues that need further attention. If so, administrative rulemaking seems preferable to the declaratory ruling process for these quasi-legislative tasks because rulemaking affords opportunity for a hearing to receive public comments and

results in a published rule.[63]

The conclusion in this decision that a CRNA who is certified as an APNP is required to work in collaboration with a physician, rather than under physician supervision, meets public policy criteria of occupational regulation. A CRNA/APNP may not perform services for which he or she is not qualified by education, training or experience. The state assures the public of the competence of the CRNA/APNP by a regulatory system that includes defined education and training requirements, an examination, experience and credentialing as an RN, professional practice standards, mandated liability insurance coverage, regulation by a related state agency, and mandated collaboration with a physician.

FINDINGS OF FACT

The Findings of Fact, below, are based on the proposals and responses of the petitioner and interested parties that are in the record. [64]

BASIC NATURE OF ANESTHESIA PRACTICE

1. Anesthesiology is a healthcare specialty concerned with the pharmacological, physiological and clinical basis of anesthesia and related fields, including resuscitation, intensive care, respiratory care, and acute and chronic pain. The practice of anesthesiology is dedicated primarily to the relief of pain and total care of the patient before, during and after surgical and obstetrical procedures.
2. The practice of anesthesiology includes:
 - a. The medical management of patients who are rendered unconscious and/or insensible to pain and emotional stress during surgical, obstetrical and certain other medical procedures. This includes pre-operative, intra-operative and post-operative evaluation and treatment of these patients;
 - b. The protection of life functions and vital organs (e.g., brain, heart, lungs, kidneys, liver) under the anesthesia and the stress of surgical and other medical procedures;
 - c. The management of airway access (both routine and difficult);
 - d. The management of problems regarding pain relief;
 - e. The management of cardiopulmonary resuscitation;
 - f. The management of routine and potential problems in pulmonary care; and,
 - g. The management of critically ill patients in special care units.
3. The practice of anesthesia requires the exercise of judgment concerning:
 - a. Selection of the appropriate drugs for anesthesia and for treatment of a patient's other medical conditions while under anesthesia;[65]
 - b. Determination that the patient is fit to undergo anesthesia;
 - c. Administration of the anesthetic, resuscitative, and related drugs during the course of the procedure and adjusting the mixture of drugs, oxygen, and other gases to keep the patient alive while anesthetized;
 - d. Monitoring the patient throughout the procedure; and,
 - e. Intervening in emergencies, such as a heart attack or an asthma attack, that a patient may suffer while under anesthesia.
4. There are different kinds of anesthesia. "General anesthesia" is the administration of drugs which causes loss of consciousness as the result of which the patient is unable to make meaningful responses. "Moderate" is the administration of a drug to induce that state of consciousness in a patient which allows the patient to tolerate unpleasant medical procedures without losing defensive reflexes, adequate cardio and the ability to respond purposefully to verbal command or to tactile stimulation if verbal response is not possible as, for example, in the case of a small child or a deaf person. "Regional anesthesia" is the administration of anesthetic agents to a patient to interrupt pain nerve impulses without loss of consciousness. It includes epidural, caudal, spinal, brachial plexus, and peripheral nerve anesthesia.
5. Notwithstanding great reductions in mortality rates from anesthesia over the past several years, the administration of anesthesia is an inherently risky process with significant potential for morbidity or mortality.

PROVIDERS OF ANESTHESIA CARE

6. Providers of anesthesia care may be divided into two basic groups: physicians specially trained in anesthesiology, and non-physician providers. The first group includes anesthesiologists, anesthesiology residents (a physician who is presently in an approved anesthesiology residency program), and other physicians with particularized training in the specialty. The second group includes CRNAs and Anesthesiology Assistants (AAs). An anesthesiologist working with either an anesthesiology resident, a CRNA, or an AA is referred to as the "Anesthesia Care Team." Others who have patient care functions during the perioperative period include post-anesthesia nurses, critical care nurses, respiratory therapists, and support personnel (anesthesia technologists and technicians, anesthesia aides, blood gas technicians, respiratory technicians, and monitoring technicians).

7. An anesthesiologist is a physician who specializes in the practice of anesthesia. Anesthesiologists function as "perioperative" physicians, meaning that the anesthesiologist is usually the single medical doctor responsible for providing comprehensive care to a patient at all stages of a surgical procedure. This includes medically evaluating the patient before the procedure, consulting with the surgical team, providing pain control, amnesia, and life support during the procedure, supervising post-operative care, and determining when a patient may safely be discharged.

EDUCATION AND TRAINING OF ANESTHESIOLOGISTS

8. Anesthesiologists must complete twelve years of formal education:

- a. Four years of science - intensive pre undergraduate education;
- b. Four years of medical school in which the individual gains knowledge of the fundamental science of the human condition (biochemistry, biophysics, anatomy, pharmacology, physiology, and pathophysiology of disease states) and receives extensive clinical instruction and experience in medical diagnosis and therapy; and,
- c. Four years of residency training that includes one year of clinical medicine and three years of clinical anesthesiology.
- d. Anesthesiologists receive extended training in pharmacokinetics, which is the quantitative study of the action of drugs in the body over a period of time including absorption, distribution, localization, biotransformation, and excretion. Knowledge of these processes is used to match the appropriate medications to a particular patient. Many anesthesiologists also elect to receive training in subspecialties such as pediatric anesthesia, critical care medicine, cardiac anesthesia, and pain management.

9. Anesthesiologists by virtue of their education and training are qualified to make medical judgments with regard to all aspects of the administration of anesthesia including, without limitation, emergency intervention and rescue from complications.

EDUCATION AND TRAINING OF CRNAS

10. CRNAs are registered nurses who have attended an accredited nurse anesthesia education program and, upon graduation therefrom, passed a national certification exam and thereby obtained national certification as a CRNA.

- a. A certified registered nurse anesthetist must graduate from a nurse anesthesia educational program accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs or its predecessors, and pass the certification examination administered by the Council on Certification of Nurse Anesthetists or its predecessors.
- b. There are more than 80 nurse anesthesia educational programs in the United States, all affiliated with, or operated by universities. Approximately one-half of those programs are located in schools of nursing or schools of health sciences or other appropriate graduate schools.
- c. The programs offered for nurse anesthesia education range from 24 to 36 months in length, depending on university requirements and all are at the master's degree level or higher.
- d. Accredited nurse anesthesia education programs provide graduate level science courses along with clinical anesthesia to prepare the student to become competent nurse anesthesia providers. The science curriculum of graduate nurse anesthesia programs includes the following:
 - i) A minimum of 135 hours in Advanced Anatomy, Physiology and Pathophysiology.
 - ii) A minimum of 90 hours in Advanced Pharmacology.
 - iii) A minimum of 45 hours of Chemistry and Physics related to anesthesia.
 - iv) The minimum requirement of 90 hours of courses in anesthesia practice provides content such as induction, maintenance, and emergence of anesthesia, airway management, anesthesia pharmacology; and anesthesia for special patient populations such as obstetrics, geriatrics and pediatrics.
 - v) Many accredited nurse anesthesia education programs provide scientific inquiry and statistics as well as active participation in student and faculty-sponsored research and clinical residencies

which allow students to learn anesthesia techniques, test theory and apply knowledge to clinical problems.

vi) Nurse anesthesia educational programs provide an average of 1,595 hours of clinical experience for each student.

11. The general requirements for admission into a nurse anesthesia education program are:

- a. A degree in nursing;
- b. A license as a registered nurse; and,
- c. A minimum of one year of acute care nursing experience.

12. In most instances, in Wisconsin, anesthesia care is typically furnished by an anesthesiologist or administered by a CRNA, AA, or anesthesiology resident, in each case acting under the direction of an anesthesiologist. The following paragraphs describe typical anesthesia care where the anesthesia care is performed by the anesthesiologist alone or by a CRNA, AA, or anesthesiology resident that is being directed by the anesthesiologist.

- a. CRNAs who have successfully completed an accredited nurse anesthesia program have the education and training necessary to successfully and independently administer anesthesia.^[66]
- b. Under Wisconsin law, a CRNA who is certified as an APNP may administer anesthesia without the supervision of a physician, but must work in a collaborative relationship with a physician.
- c. Under Wisconsin law, a CRNA who is not certified as APNP may administer anesthesia only as directed, supervised and inspected by a physician.

13. The specific tasks involved in anesthesia care, which are described in the following paragraphs, are generally performed by: (1) an anesthesiologist; or (2) a CRNA, AA, or anesthesiology resident^[67]. The particular tasks that the anesthesiologist reserves for himself/herself to perform are variable by the institution, by the normal practice of each anesthesiologist in that institution, and by the particular circumstances in each instance of anesthesia care. The particular tasks assigned to each CRNA, AA, or anesthesiology resident are also variable by the institution, by the normal practice of each anesthesiologist in that institution, and by the particular circumstances in each instance of anesthesia care.

14. Typically, a patient goes to a primary care physician for a routine check up or with a medical complaint. If the physician sees the potential need for a surgical procedure, the physician refers the patient to a surgeon. The surgeon then reviews the patient record, examines the patient and determines the following: (1) if a surgical procedure is indeed needed; (2) the type of surgical procedure needed; and, (3) the benefits and risks of the procedure based on the procedure and the patient's health. The surgeon then provides the patient with information on the procedure and the benefits and risks of the procedure. If a procedure is deemed necessary and the patient consents to the procedure, the patient is then scheduled for the procedure by the surgeon or his/her office personnel.

15. A patient who will receive anesthesia in connection with such procedure typically receives the following pre-operative care:

a. At some point following the initial appointment with the surgeon, and prior to the procedure, the patient receives an anesthetic preoperative assessment work-up. This consists of a careful and concise review of the patient's medical record and pertinent labs and tests. Included in the review are details on patient current history of medical illness or injury, past medical history, past surgical and anesthetic history (including complications or adverse reactions that occurred), review of patient's blood relative anesthetic complications, review of organ systems and organ pathology with the potential influence on the management of anesthesia (neurological, cardiovascular, pulmonary, gastrointestinal, renal, hepatic, musculoskeletal, endocrine, gynecological, urological, and hematological), review of current vital signs (blood pressure, heart rate, temperature, respirations), review of allergic reactions (medication, latex, food) and current drug regimen, notation of the time of last food or fluid consumption as part of the analysis of risk of aspiration, and review of laboratory data and radiological studies that could influence the management of anesthesia. When conducting such a review, it is extremely important to be able to recognize certain symptoms of illness or infirmity (sometimes subtle), which may have serious consequences or lead to complications when the patient is exposed to an anesthetic. Examples of instances in which recognition of subtle symptoms are necessary include patients who may have undiagnosed sleep apnea and patients who may have undiagnosed cardiac ischemia. If such symptoms are not recognized and diagnosed prior to the procedure, the administration of anesthesia could have serious consequences. In the case of an undiagnosed sleep apnea, there could be issues with airway placement, ventilation in the operating room, and post-operative ventilation.

a.1. This anesthetic preoperative review may be performed by the anesthesiologist assigned to the procedure (if known ahead of time), or it may be done prior to the time that the anesthesia assignments are made. When the anesthetic preoperative review is done prior to the time that anesthesia personnel assignments

are made for a procedure, it may be performed by: (1) another anesthesiologist; (2) a CRNA; (3) an AA; (4) an anesthesiology resident; or (5) a nurse working in the anesthesia preoperative work clinic or surgical clinic, or assigned to perform daily anesthetic preoperative work-ups. Typically, there is a department standardized preoperative sheet, which contains lists of desired information and tests to be collected from the patient record, that is filled out. Once assignments are made, the preoperative anesthesia work is always thoroughly reviewed by the anesthesiologist when an anesthesiologist is in charge of the anesthetic.[68]

a.2. Next a physical exam of the patient is performed, focusing on cardiac and pulmonary systems, organ systems which the surgery involves, organ systems that the patient expresses concern about, and organ systems of concern following patient chart review and history. The patient airway is then examined for signs of potential difficulty with airway management or intubation (placement of a breathing tube). This physical exam and airway exam are usually performed by both the staff anesthesiologist responsible for the anesthetic plan, delivery, and postoperative care of the patient, and by the non-physician provider (CRNA, AA) or anesthesiology resident, if also assigned to deliver the anesthetic.

b. Following review of history, review of surgical procedure, and physical exam, an anesthetic management plan is developed consisting of the decision on type of anesthetic to be delivered (general, regional: spinal or epidural, peripheral nerve block, monitored anesthesia care), plan for airway management, determination of invasive vascular catheters to be placed (peripheral I.V., arterial line, central venous line), and determination of monitors needed including standard monitors (electrocardiogram, non-invasive blood pressure, pulse oximetry, capnography, temperature) and invasive monitors (arterial blood pressure, central venous pressure, and pulmonary artery catheter allowing for the measurement of right atrial, right ventricular, left atrial, and cardiac output measurements). Consideration of other monitors/tests needed for the surgical procedure (EEG, somatosensory evoked potentials) is given, as these may also influence choice of anesthetic.

c. The anesthesiologist and other Anesthesia Care Team members (CRNA, AA, or anesthesiology resident) talk to the patient and give the patient the information regarding: (1) the anesthetic plan to be delivered; (2) the monitoring of the patient that will occur during the procedure, including any invasive lines that will be placed for monitoring purposes; and (3) the benefits and risks of the particular type of anesthesia and monitors and invasive lines that will be used.[69]

d. The anesthesiologist or other involved physician signs orders for any pre-operative drugs that will be given to the patient prior to the procedure. A CRNA with prescriptive authority may also prescribe pre-operative drugs pursuant to the CRNA's own DEA number and prescriptive authority.

e. Following approval, the anesthetic plan is then carried out by the anesthesiologist if working alone, or by the CRNA, AA, or anesthesiology resident.[70]

16. The dispensing of anesthesia is usually performed by an anesthesiologist, CRNA, AA, or anesthesiology resident. The anesthesiologist, CRNA, AA, or anesthesiology resident go to the pharmacy and check out the narcotics that were prescribed pursuant to the anesthesia plan. The anesthesiologist, CRNA, AA, or anesthesiology resident will then place the medications in the operating room. In addition, there is typically a cart in the operating room that has the non-narcotic standard medications available.

17. Shortly before the administration of anesthesia, the anesthesiologist, CRNA, AA, or anesthesiology resident inspects and sets-up the anesthesia machine. The anesthesia machine includes a source of compressed gases, a breathing system, a ventilator, anesthetic vaporizers, and flowmeters to deliver known flows and concentrations of anesthetic gases into the breathing system. Suction, monitors, drugs, and airway equipment are also set-up in the operating room.

18. As with the other tasks involved in anesthesia care, the tasks involved in the actual administration of anesthesia are performed by (1) the anesthesiologist; or (2) a CRNA, AA, or anesthesiology resident.[71] When the CRNA, AA, or anesthesiology resident acts under the direction of the anesthesiologist, an anesthesiologist is either in the room of the procedure or is available to reach the room of the procedure within minutes of being paged to the room. Depending on the type of anesthesia involved, the administration of anesthesia typically proceeds as follows:

a. General anesthesia.

i. A peripheral I.V. catheter is usually put in place (with the exception of the pediatric patient who may be put to sleep via mask induction), and in many instances, a sedative, anxiolytic (anxiety reducing medication), and/or amnestic (medicine decreasing ability to remember) is given to the patient. The patient is then transported to the operating room and placed on the operating room table. All non-invasive monitors are placed, and in some instances, when needed to monitor the patient for anesthetic induction (delivery of the anesthetic to achieve an unconscious state) invasive monitors are also placed (i.e. arterial line or central venous line).

ii. The patient's vital signs are continuously monitored and recorded on the anesthetic record every five minutes, or more frequently as needed. Blood pressure and heart rate are usually maintained at the patient's normal baseline value, however, for some cases it is preferred that the patient's blood pressure be maintained

slightly hypertensive (above normal) to maintain cerebral (brain) perfusion pressure, or slightly hypotensive (below normal) to decrease the amount of bleeding. Intravenous fluid is delivered at a rate determined by the patient's hourly normal requirement, and the amount needed for replacement of blood and body fluid lost during the procedure. Loss of blood, plasma, and coagulation factors are monitored during the procedure, and products are replaced as needed. Patient temperature is maintained at a normal level.

iii. The patient is pre-oxygenated with a mask and breathing system containing 100% oxygen for approximately 5-6 minutes. If the patient is not at risk for aspiration or potential difficult airway, I.V. induction of anesthesia occurs with the delivery of a hypnotic drug. This produces a rapid onset of unconsciousness. Once it is determined that the patient can be ventilated by mask, an intravenous paralytic drug is given. This causes muscle paralysis that facilitates direct laryngoscopy for intubation of the trachea (placement of a breathing tube in the trachea). A breathing tube is then placed into the patient's trachea. The placement of the breathing tube in the patient's trachea is then confirmed by the presence of end tidal carbon dioxide (capnography showing the patient exhalation of carbon dioxide), and patient breath sounds on auscultation (listening) of the lungs.

iv. If the patient is at risk for aspiration, a "rapid sequence induction" is performed. In a rapid sequence induction, the patient is given a hypnotic that is immediately followed by a dose of a very rapid acting paralytic drug. Cricoid pressure (pressure held over the cricoid cartilage on the neck which occludes the esophagus) is maintained on the patient's neck and esophagus until the breathing tube is inserted, and placement in the trachea is confirmed.

v. If the patient presents a potentially difficult airway (i.e. it is unlikely that a breathing tube can be placed by routine direct laryngoscopy), a fiberoptic scope may be used for placement of the breathing tube. If its use is anticipated, this equipment is set up in advance of patient induction of anesthesia. Following placement of the airway breathing tube, the patient is usually placed on the ventilator, which is set to deliver an adequate volume of breathing gases and oxygen at a specific rate. The patient is maintained in a pain-free asleep state with the continued delivery of anesthetic and narcotics. Muscle paralysis is maintained and monitored as needed for the surgical procedure. Antibiotics are administered to prevent infection prior to the beginning of the procedure, and re-dosed as needed.

vi. Following the end of procedure, in most instances, the patient is allowed to awaken. Delivery of the anesthetic is discontinued, and the patient is extubated (breathing tube removed) when it is determined that he or she is sufficiently awake with adequate airway reflexes to prevent aspiration. The patient is then transported either to the post-anesthesia care unit (PACU) or the intensive care unit (ICU). The patient is placed on appropriate monitors and vital signs are taken. Report of the patient's pre-operative history, and intraoperative history and management is given to the attending nurse. Post-operative orders for blood pressure management, pain management, fluid management, and postoperative nausea management are written.

b. Moderate sedation (monitored anesthesia care - "MAC").

i. The administration of moderate sedation (MAC) includes the steps outlined in section (i) of the above description of the administration of general anesthesia.

ii. The administration of moderate sedation (MAC) includes the steps outlined in section (ii) of the above description of the administration of general anesthesia.

iii. The patient is sedated with medications (usually a mix of anxiolytic, amnesic agents, hypnotic agents and narcotics). Care is exercised to not over sedate the patient to the point that supplemental respiration needs to be initiated. Supplemental oxygen is delivered as needed, usually by nasal cannula (tubing placed in the nose to deliver oxygen). The patient's respirations are constantly monitored and should the patient become over-sedated, respirations are supported.

c. Administration of regional anesthesia.

i. The administration of regional anesthesia includes the steps outlined in section (i) of the above description of the administration of general anesthesia.

ii. The administration of regional anesthesia includes the steps outlined in section (ii) of the above description of the administration of general anesthesia.

iii. Spinal or epidural catheter/medication is placed in the preoperative area, block room, or the operating room prior to surgery. In all instances, sterile technique is applied. Spinal, epidural and caudal blocks are referred to as regional or conduction block anesthesia. A spinal block is produced by the injection of a local anesthetic solution into the lumbar subarachnoid space (the space containing spinal fluid). An epidural block is produced with the injection of a local anesthetic into the epidural space usually at the lumbar or thoracic level that allows for a spread to get pain relief coverage in the area of surgical incision. A caudal block is performed by placing local anesthetic in the epidural space via a needle introduced through the sacral hiatus. For placement of spinal local anesthetic, the patient is usually placed in the sitting or lateral position. The vertebral level in which

the anesthetic is to be placed is determined. The patient's area of skin over the vertebral level to be injected is sterilely prepped with an antiseptic solution and draped. A small amount of subcutaneous local anesthetic is injected, to allow for the placement of the spinal needle. A spinal needle is placed between two spinous processes, and advanced through the supraspinous ligament, ligamentum flavum and dural matter). The needle is advanced until cerebral spinal fluid flows from the site of injection. This signals that the subarachnoid space has been entered, and the local anesthetic is then injected. After injection, the needle is removed. The patient is then laid down in the supine position. The patient's level of anesthetic (numbness) is assessed with pinprick, or ability to feel cold. The patient (if not in the operating room) is then transported to the operating room and placed on the operating room table. All non-invasive monitors are placed, and in some instances, invasive monitors are also placed.

iv. For placement of epidural local anesthetic, or epidural catheter for the continuous delivery of local anesthetic, the patient is usually placed in the sitting or lateral position. The vertebral level in which the anesthetic is to be placed is determined. The patient's area of skin over the vertebral level to be injected is sterilely prepped with an antiseptic solution and draped. A small amount of subcutaneous local anesthetic is injected, to allow for the placement of the epidural needle. A common method for identifying the epidural space is the "loss of resistance" technique. An epidural needle is placed between two spinous processes, and advanced into the supraspinous ligament. After advancement into the ligamentum flavum, a glass syringe filled with air or sterile saline is attached. If the needle is correctly placed in the ligament, it will be difficult to inject the air or saline, and when the plunger is lightly pushed, it will "bounce back". The needle is advanced with continuous pushing on the plunger, until the air/saline has a sudden loss of resistance, signaling entrance into the epidural space. Local anesthetic can then be injected, or at this point, a catheter can be introduced through the needle, into the epidural space. The needle is then removed. The patient is then laid down supine. The patient's level of anesthetic (numbness) is assessed with pinprick, or ability to feel cold ice. The patient (if not in the operating room) is then transported to the operating room and placed on the operating room table. All non-invasive monitors are placed, and in some instances, invasive monitors are also placed. The patient is sedated as in the case of moderate sedation as described above.

v. The administration of regional anesthesia includes the steps outlined in section (iii) of the above description of the administration of moderate sedation (MAC).

vi. Following the end of procedure, post-operative orders for blood pressure management, pain management, fluid management, and post-operative nausea management, are issued.^[72] Possible complications of spinal block include hypotension (due to sympathetic nerve blockade and resulting venous pooling (widening of the veins which then hold more blood volume) and decreased venous return (decrease in blood return to the heart), or block of cardioaccelerator fibers (nerves that cause heart rate to increase) contributing to bradycardia (slow heart rate) and decreased cardiac output, post spinal headache, high spinal (which can result in inability to breathe or unconsciousness), nausea and vomiting, backache, or neurological sequelae/injury. Complications of epidural block are similar to those of spinal block, with the added risk of accidental dural puncture resulting in leak of spinal fluid and post dural puncture headache.

d. Administration of a peripheral nerve block.

i. The administration of a peripheral nerve block includes the steps outlined in section (i) of the above description of the administration of general anesthesia.

ii. The administration of a peripheral nerve block includes the steps outlined in section (ii) of the above description of the administration of general anesthesia.

iii. A peripheral nerve block is placed by locating the peripheral nerve supplying the area involved with the surgery, sterile prep and drape of the area in which the block is to be placed. Delivery of an adequate amount of local anesthetic is made via a sterile syringe and needle to the area surrounding the peripheral nerve to be anesthetized. Location of the nerve is often performed with the use of an electrical peripheral nerve stimulator, or ultrasound. Examples of peripheral nerve blocks are median, radial, or ulnar nerve blocks for hand surgery, axillary nerve block for arm and hand surgery, femoral sciatic nerve blocks for knee surgery or amputation of the lower extremity, ankle block for foot or toe surgery. The patient's respirations are constantly monitored, and should they become over sedated, respirations are supported.

iv. The administration of a peripheral nerve block includes the steps outlined in section (iii) of the above description of the administration of moderate sedation (MAC).

19. The monitoring of general anesthesia, moderate sedation (MAC), regional anesthesia, or peripheral nerve block during a procedure includes the following:

a. The patient's oxygenation is continually evaluated. Methods of continual evaluation of the patient's oxygenation include the following:

- i. Inspired gas (i.e. delivering gas to a patient so that the patient has an adequate level of oxygen). During every administration of general anesthesia using an anesthesia machine, the concentration of oxygen in the patient breathing system is measured by an oxygen analyzer with a low oxygen concentration limit alarm in use.
 - ii. Blood oxygenation: During all anesthetics, a quantitative method of assessing oxygenation such as pulse oximetry (a device that shines two frequencies of light through skin and measures the percentage of hemoglobin carrying oxygen) is employed. When the pulse oximeter is utilized, the variable pitch pulse tone and the low threshold alarm is audible. Adequate illumination and exposure of the patient are necessary to assess color.
 - b. The patient's ventilation is continually evaluated. Methods of continual evaluation of the patient's ventilation (ensuring the provision of both oxygen and carbon dioxide to a patient) include the following:
 - i. The patient's qualitative clinical signs are monitored such as chest excursion (the rising and falling of the chest), observation of the reservoir breathing bag (if a patient is breathing on his or her own, operating room personnel can observe the bag and see it move as a patient breathes) and auscultation (listening with a stethoscope to each side of the chest) of breath sounds. Continual monitoring for the presence of expired carbon dioxide is performed unless invalidated by the nature of the patient, procedure or equipment. Quantitative monitoring of the volume of expired gas is often conducted.
 - ii. When an endotracheal tube or laryngeal mask is inserted, its correct positioning is verified by clinical assessment and by identification of carbon dioxide in the expired gas. Continual end-tidal carbon dioxide analysis (amount of carbon dioxide that is expelled by the patient), in use from the time of endotracheal tube/laryngeal mask placement until extubation/removal or initiating transfer to a postoperative care location, is performed using a quantitative method such as capnography (a machine that measures carbon dioxide levels). When capnography is utilized, the end tidal carbon dioxide alarm is audible when necessary.
 - iii. When ventilation is controlled by a mechanical ventilator, a device is continuously used that is capable of detecting disconnection of components of the breathing system. The device gives an audible signal when its alarm threshold is exceeded.
 - iv. During regional anesthesia and monitored anesthesia care, the adequacy of ventilation is evaluated by continual observation of qualitative clinical signs (such as chest wall movement and pulse oximetry readings), and/or monitoring for the presence of exhaled carbon dioxide.
 - c. The patient's circulatory function is continually evaluated. Methods of continual evaluation of the patient's circulatory function include the following:
 - i. Every patient receiving anesthesia is monitored with an electrocardiogram (machine that monitors for heart rate, heart rhythm, and heart ischemia), which continuously monitors heart function from the time that anesthesia is first administered until the patient leaves the operating room;
 - ii. Every patient receiving anesthesia has his or her blood pressure and oxygen saturation monitored and evaluated every five minutes during the administration of anesthesia; and
 - iii. Every patient receiving general anesthesia has his or her circulatory function continually evaluated during the administration of anesthesia by one or more of the following: taking a pulse, listening to heart sounds, monitoring a tracing of intra-arterial pressure, or pulse oximetry.
 - d. There must be the capability to continually monitor a patient's body temperature.
 - e. Additional invasive monitoring (i.e. central venous line or arterial line) may be used on the patient.^[73]
 - f. If a general anesthetic is used and a physician is not a member of the operating team, a physician shall be immediately available in the hospital or an adjacent clinic to assist in emergency situations.^[74]
20. Following completion of the administration of anesthesia, the following care is afforded the patient:
- a. The patient is evaluated.
 - b. The care of the patient is directly transferred to a qualified health care professional in the post-anesthesia care unit (PACU)/recovery room or the intensive care unit (ICU).^[75] Such professional must be capable of monitoring the patient's vital signs. The professional must also be capable of assessing the patient for pain, nausea/vomiting, and complications that can arise from surgery and anesthesia (i.e. hypertension, hypoxia, etc.). Should complications occur, the professional must immediately notify a physician. Such individual must also be trained to administer medications as required for analgesia, nausea/vomiting, or other indications.
 - c. Monitoring in the recovery area includes pulse oximetry, non-invasive blood pressure monitoring, heart rate monitoring, and invasive monitoring (arterial line, central venous line) as necessary.
 - d. The patient is assessed periodically for level of consciousness, pain complaints, and complications, should they occur.

e. The patient's vital signs and clinically relevant findings are documented in the patient's medical record.

21. After the following criteria are met, the patient may be discharged from the PACU or ICU:

- a. The patient's vital signs are stable;
 - b. The patient's oxygen saturation levels are stable;
 - c. The patient's mental status has returned to the same mental status that the patient had prior to the procedure;
 - d. The patient's pain is being adequately controlled;
 - e. Any bleeding, nausea, or vomiting experienced by the patient is minimal;
- and,
- f. There is resolution of the neuraxial blockade (the numbing caused by the spinal or epidural must wear off so that there is a return of function to the affected area of the patient's body).

22. If a patient is scheduled to leave the medical facility the day of the procedure, the patient may be discharged from the medical facility when the following additional criteria are met:

- a. The patient can be discharged in the company of a competent adult; and,
- b. The patient has received understandable instructions that explain the following:
 - i. Telephone numbers that the patient can use to contact a physician to discuss complications or questions about post-operative care;
 - ii. Instructions for medications prescribed and pain management;
 - iii. Information regarding the patient's follow-up visit; and,
 - iv. Information regarding the designated treatment hospital in case of emergency.

23. In some instances, particularly in rural areas, anesthesia is administered by a CRNA under the supervision of a non-anesthesiologist physician such as a surgeon. In such instances, while the non-anesthesiologist physician's role and responsibilities are comparable to the above described roles and responsibilities of anesthesiologists, the specific tasks reserved to the supervising physician and those assigned to the CRNA will vary by institution, by the normal practice of each supervising physician in that institution, and by the particular circumstances in each instance of anesthesia care.

a. In some instances where the CRNA does not have prescriptive authority, particularly in a rural area, a physician, APNP or other authorized prescriber may prescribe the anesthetic medications which are administered by the CRNA.

EXAMPLES OF EMERGENCY ANESTHESIA COMPLICATIONS

24. The following paragraphs set out how some representative emergency anesthesia complications would generally be managed by an anesthesiologist and a CRNA, AA or anesthesiology resident working under the direction of the anesthesiologist.

a. CRNAs who have successfully completed an accredited nurse anesthesia program have the education and training necessary to successfully and independently administer anesthesia and respond to the emergencies described in the following paragraphs.

25. For example, a 56-year old man undergoes an uneventful laparoscopic cholecystectomy (surgical removal of the gallbladder through a tiny incision at the navel). The patient's past medical history is significant for smoking, hypertension, sleep apnea (a condition in which patients have abnormal ventilatory patterns), and obesity. Ten minutes after arrival to the post-anesthesia care unit, the post-anesthesia care nurse/the intensive care unit nurse notices that the patient is tachycardic (the patient's pulse is too high at 110 beats per minute). The patient's oxygen saturation is 88% on 100% inspired oxygen by facemask (oxygen saturation is supposed to be approximately 93-100% on room air). The nurse then checks to make sure the monitor is on and the oxygen is on the patient. If the nurse finds that both the monitor and the oxygen are working correctly, the nurse will call an anesthesiologist or a non-anesthesiologist physician. The anesthesiologist and the physician will immediately come to the patient's bedside. Because of the high pulse rate and the low oxygen saturation, the patient is considered to have post-operative hypoxemia (low oxygen levels). The following sets out the differential diagnosis and treatment for post-operative hypoxemia. The likelihood of a successful outcome depends greatly on making a prompt and correct diagnosis.

a. The post-operative hypoxemia could be caused by airway obstruction, which most commonly occurs in the pharynx or the area behind the tongue. This diagnosis is made from the patient's known history of sleep apnea and physical exam, revealing obstructive breathing and a dulled mental status. In this situation, the anesthesiologist or other physician also needs to determine if the patient's condition is due to narcotics or residual muscle relaxation, both of which can worsen airway obstruction. Initial treatment of this problem involves tilting the head of the patient backwards and/or

manually moving the jaw forward until the obstruction is relieved. If the patient's condition is due to narcotics, the patient may need medication (Naloxone) to reverse the narcotics' effect. If the patient's condition is due to residual muscle relaxation, the patient will need additional medications to increase strength and muscle tone. In severe cases of airway obstruction, the patient will require assisted ventilation with a mask and/or reintubation. The patient will also need further observation to make sure that the problem does not recur.

b. The patient's post-operative hypoxemia could be caused by inadequate pain relief. If the patient complains of inadequate pain relief, treatment consists of the administration of more analgesic medication.

c. The patient's post-operative hypoxemia could be caused by atelectasis of the lungs (temporary collapse of lung segments, decreasing the lungs' ability to oxygenate the blood). This complication is common after this procedure, particularly in an obese person. This complication can also be caused by secretions and/or blood, which can plug airway segments and cause their collapse. Atelectasis of the lungs would be diagnosed by physical exam (decreased breath sounds at the lung bases) and chest x-ray (decreased lung volumes at the base of the lungs). To treat atelectasis, the patient is given humidified oxygen, repositioned into a sitting position, and encouraged to breathe deeply. If the patient does not improve, there are other, more serious problems that have to be considered as described below.

d. The patient's post-operative hypoxemia could be caused by a pneumothorax (air trapped in the chest cavity). Pneumothorax is a known complication of laparoscopy. Pneumothorax is diagnosed by physical exam (breath sounds are decreased on the affected side) and chest x-ray (air is identified in the space around the lung tissue). The treatment for pneumothorax depends on the size of the pneumothorax and the patient's condition. A small pneumothorax (less than 20% of the lung cavity) that is not compromising the patient's condition may be treated with oxygen and observation until it resolves on its own. A larger pneumothorax (greater than 20% of the lung cavity) usually requires insertion of a tube into the patient's chest; this tube over time drains the air and allows the lung to heal and re-expand. Most patients with a pneumothorax should be observed in an intensive care unit (ICU) until the pneumothorax resolves or shrinks significantly. If not diagnosed promptly, pneumothorax can progress to a life-threatening condition, tension pneumothorax, in which the trapped air acutely decreases blood flow to the lungs and the heart's ability to pump blood. The diagnosis of tension pneumothorax must be made quickly; treatment consists of rapid placement of a chest tube (as described above) or a large intravenous cannula into the anterior chest in order to relieve the pressure on the lungs and heart.

e. The patient's post-operative hypoxemia could be caused by coronary ischemia (not enough oxygen getting to the heart), leading to reduced blood flow from the heart and pulmonary edema (fluid on the lungs). Coronary ischemia is diagnosed by the patient's history (assuming the patient reports chest pain or other symptoms suggesting ischemia), a physical exam (rales, crackling sounds in the lung bases that suggest heart failure) and 12-lead electrocardiogram (ECG). The ECG done at this time needs to be compared to the ECG done on the patient before surgery. In this comparison, the physician looks for any changes suggestive of ischemia and impending damage to the heart. The initial treatments for coronary ischemia aim to increase oxygen supply to, and reduce oxygen demand from, the heart. Therefore, the patient typically receives supplemental oxygen and medications such as beta-blockers, which reduce oxygen demand, and nitrates, which reduce oxygen demand and improve oxygen supply. Depending on the patient's condition, invasive monitoring (arterial line, central line) might be needed. In addition, a cardiologist must be consulted as soon as possible. If the patient's condition improves, the patient is likely transferred to the ICU for observation. If the patient's condition does not improve, the patient may need emergency cardiac catheterization to diagnose and treat coronary blockages before a heart attack occurs.

f. The patient's post-operative hypoxemia could be caused by an asthmatic attack. An asthmatic attack would be diagnosed primarily by physical exam revealing tachypnea (fast breathing) and wheezing. The treatment for an asthmatic attack includes the administration of humidified oxygen, medications to improve airflow in the lungs (nebulized bronchodilators), and steroids for stabilization. If the patient's condition is severe, the patient may need epinephrine (adrenalin, which causes immediate relaxation of the airways), invasive monitoring (arterial line) with frequent blood sampling to measure pH, oxygen, and carbon dioxide), or possibly reintubation.

g. The patient's post-operative hypoxemia could be caused by aspiration pneumonia (stomach contents passing into the lungs). Aspiration pneumonia would be diagnosed by looking at the patient's history (an event in the operative period suggesting aspiration), physical exam (decreased breath sounds, rales or both), and chest x-ray (though this might not be clear in the immediate stages). Aspiration pneumonia, though rare, has high mortality if not treated aggressively and promptly. The treatment for aspiration pneumonia would include the administration of oxygen and steroids. The patient may also need intubation, bronchoscopy and lavage (flushing the lungs with saline solution), and observation in the ICU.

h. The patient's post-operative hypoxemia could be caused by a pulmonary embolism (blockage in the pulmonary blood vessels caused by a blood clot or air bubble). Pulmonary embolism is suspected in a patient when the patient experiences sudden rapid breathing, chest pain, shortness of breath, or pulmonary effusion (fluid on the lungs). The symptoms of pulmonary embolism are vague and overlap with those of asthma or heart failure. If a pulmonary embolism is suspected, the treatment can range from oxygen to reintubation and pharmacologic support of blood pressure.

26. For example, a patient undergoing plastic surgery is receiving local anesthesia via an injection into the chest and

develops symptoms such as shortness of breath, hypotension (a drop in blood pressure), or tachycardia (an unusually fast heartbeat). These symptoms might evidence one of a number of different causes, ranging from inadequate amounts of anesthesia, an allergic reaction to the anesthesia, a pulmonary embolus (a blood clot in the lung or injected air into a major blood vessel), surgical bleeding (bleeding resulting from the surgery itself or bleeding caused by an injection of anesthesia that interrupts a major artery), a hemothorax (i.e. a needle puncture of a major artery), or a pneumothorax (i.e. a punctured lung caused by a needle). Each potential cause indicates a different form of treatment. For example, the treatment for light anesthesia would be to deepen the anesthesia. The treatment for an allergic reaction to the anesthesia could include treating the patient with vasopressors, giving the patient fluids, or giving the patient adrenaline. If the patient stops breathing due to the allergic reaction, the patient must be resuscitated. The treatment for a pulmonary embolus would include supporting the patient's blood pressure and the placement of invasive lines. The treatment for a pulmonary embolus could also include the administration of drugs such as dopamine if a patient becomes hypotensive due to the pulmonary embolus. The treatment for surgical bleeding is to find the site of the bleeding and to stop the bleeding. The treatment for either a pneumothorax or a hemothorax would include insertion of a chest tube to either fill the lung or to drain the lung.

27. Patients whose hearts have been damaged from previous heart attacks may undergo surgical procedures involving blood loss, during which their blood pressure drops suddenly. When that happens, it must be determined what caused the drop in pressure. If the drop in pressure was caused by the drugs required to anesthetize the patient (some drugs are potent vasodilators or cardiac suppressants), the treatment may require administration of drugs which will raise blood pressure (vasoconstrictors to increase heart contractility or rate). If the drop in pressure was caused by the loss of blood, the proper response would be to rapidly administer fluid and blood. Treatment may also require the administration of drugs designed to raise the blood pressure. However, if the patient is actually suffering an attack of myocardial ischemia (inadequate oxygen to the heart), the proper response might not include the rapid administration of blood or the administration of drugs designed to raise the blood pressure. The proper response to an attack of myocardial ischemia would include optimizing the level of oxygen, decreasing stress on the heart, supporting blood pressure, and providing the patient with aspirin. If the course of emergency response is erroneously chosen (i.e. the patient is given blood or fluid when instead the patient should have received blood pressure or heart support), the heart may not be able to handle the influx of a large volume of fluid and may go into cardiac arrest.

CONCLUSIONS OF LAW

- I. The Medical Examining Board has jurisdiction to decide this matter and has authority under Wis. Stat. § 227.41 to issue a declaratory ruling or to decline to issue a declaratory ruling.
- II. Petitioner WSA has not shown that it is entitled to a judgment on its Motion for Summary Judgment as a matter of law.
- III. The administration of anesthesia is part of the practice of medicine and surgery within the meaning of Wis. Stat. §§ 448.01 and 448.03(1).
- IV. The administration of anesthesia is the practice of the practice of professional nursing within the meaning of Wis. Stat. §441.001(4)(intro).
- V. A Certified Registered Nurse Anesthetist (CRNA) who is certified as an Advanced Practice Nurse Prescriber (APNP) and who administers anesthesia is lawfully practicing within the scope of a certificate granted to practice professional nursing under Wis. Stat. ch. 441.
- VI. A Certified Registered Nurse Anesthetist (CRNA) who is certified as an Advanced Practice Nurse Prescriber (APNP) and who administers anesthesia, is practicing within Wis. Stat. § 448.03(2)(a), an exception to the general requirement for physician licensing in Wis. Stat. § 448.03(1)(a), and is not required to have a license as a physician or be supervised by a physician.
- VII. A Certified Registered Nurse Anesthetist (CRNA) who is certified as Advanced Practice Nurse Prescriber (APNP) is required by Wis. Adm. Code § N 8.10(7) to work in a collaborative relationship with a physician.
- VIII. A Certified Registered Nurse Anesthetist (CRNA) who is not certified as Advanced Practice Nurse Prescriber (APNP) and who administers anesthesia, is practicing within Wis. Stat. § 448.03(2)(e), an exception to the general requirement for physician licensing in Wis. Stat. § 448.03(1)(a), and is not required to have a license as a physician, but is required to provide patient services, including administration of anesthesia, as directed, supervised and inspected by a physician.

Based on the record in this matter, the undersigned administrative law judge recommends that the State of

Wisconsin Medical Examining Board issue the following:

ORDER

NOW, THEREFORE, IT IS ORDERED That the Motion for Summary Judgment of the Petitioner Wisconsin Society Anesthesiologists shall be, and hereby is, DENIED;

IT IS FURTHER ORDERED That the Petition for Declaratory Ruling of the Wisconsin Society of Anesthesiologists shall be, and hereby is, DISMISSED.

/s/ William Dusso

William Dusso
Administrative Law Judge
Wisconsin Department of Regulation and Licensing
Dated: January 22, 2007

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[1] Administrative rules of the BON define "advanced practice nurse" to include a registered nurse who has a current license to practice professional nursing and is currently certified by an approved national certifying body as a "certified registered nurse anesthetist." "Nurse anesthetist" is defined in Wis. Stat. § 655.001(9) as "... a nurse licensed under ch. 441 ... who is certified as a nurse anesthetist by the American Association of Nurse Anesthetists. Under Wis. Adm. Code § HFS 118.03 (27) "Nurse anesthetist" means a professional nurse licensed under ch. 441, Stats., who has obtained, through additional education and successful completion of a national examination, a certification as an anesthesia nursing specialist." Other similar definitions are at Wis. Adm. Code § HFS 105.055(1), and 42 CFR 410.69(b).

[2] The rule was published on November 13, 2001 at 66 FR 56762. The regulations adapted and amended 42 CFR Parts 416, 482, and 485. The

full text of the *Federal Register* adopting these regulations is at Tab A to *Memorandum Of Petitioner In Support Of Motion For Summary Judgment* and Exhibit B of WANA's *Memorandum In Opposition To The Summary Judgment Motion Of The Wisconsin Society of Anesthesiologists*. As amended, the conditions of participation for hospital anesthesia services, for example, state as follows:

TITLE 42--PUBLIC HEALTH

CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES--(Continued)

PART 482--CONDITIONS OF PARTICIPATION FOR HOSPITALS . . .

Subpart D--Optional Hospital Services . . .

Sec. 482.52 Condition of participation: Anesthesia services.

If the hospital furnishes anesthesia services, they must be provided in a well-organized manner under the direction of a qualified doctor of medicine or osteopathy. The service is responsible for all anesthesia administered in the hospital.

(a) Standard: Organization and staffing. The organization of anesthesia services must be appropriate to the scope of the services offered. Anesthesia must be administered only by--

- (1) A qualified anesthesiologist;
- (2) A doctor of medicine or osteopathy (other than an anesthesiologist);
- (3) A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law;
- (4) A certified registered nurse anesthetist (CRNA), as defined in Sec. 410.69(b) of this chapter, who, unless exempted in accordance with paragraph (c) of this section, is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed; or

(5) An anesthesiologist's assistant, as defined in Sec. 410.69(b) of this chapter, who is under the supervision of an anesthesiologist who is immediately available if needed.

(b) Standard: Delivery of services. Anesthesia services must be consistent with needs and resources. Policies on anesthesia procedures must include the delineation of preanesthesia and post anesthesia responsibilities. The policies must ensure that the following are provided for each patient:

(1) A preanesthesia evaluation by an individual qualified to administer anesthesia under paragraph (a) of this section performed within 48 hours prior to surgery.

(2) An intraoperative anesthesia record.

(3) With respect to inpatients, a postanesthesia followup report by the individual who administers the anesthesia that is written within 48 hours after surgery.

(4) With respect to outpatients, a postanesthesia evaluation for proper anesthesia recovery performed in accordance with policies and procedures approved by the medical staff.

(c) Standard: State exemption. (1) A hospital may be exempted from the requirement for physician supervision of CRNAs as described in paragraph (a)(4) of this section, if the State in which the hospital is located submits a letter to CMS signed by the Governor, following consultation with the State's Boards of Medicine and Nursing, requesting exemption from physician supervision of CRNAs. The letter from the Governor must attest that he or she has consulted with State Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the State and has concluded that it is in the best interests of the State's citizens to opt-out of the current physician supervision requirement, and that the opt-out is consistent with State law.

(2) The request for exemption and recognition of State laws, and the withdrawal of the request may be submitted at any time, and are effective upon submission.

[3] The opt-out provisions are in 42 CFR §§ 416.42(d), 482.52(c), and 485.639(e). A copy of Gov Doyle's letter is Exhibit 1 to Petitioner's *WSA Exhibits Binder* submitted with Petitioner's *Memorandum Of Petitioner In Support Of Motion For Summary Judgment* and Exhibit C of WANA's *Memorandum In Opposition To The Summary Judgment Motion Of The Wisconsin Society of Anesthesiologists*.

[4] Acronyms used in this decision are:

AA - Anesthesiology Assistants.

AANA - American Association of Nurse Anesthetists.

APN - Advanced practice nurse.

APNP - Advanced Practice Nurse Prescriber.

BON - State of Wisconsin Board of Nursing.

CMS - U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services.

CRNA - Certified Registered Nurse Anesthetist.

CRNA/APNP - A Certified Registered Nurse Anesthetist who is certified by the Board of Nursing as an Advanced Practice Nurse Prescriber.

DHFS - State of Wisconsin Department of Health and Family Services.

DRL - State of Wisconsin Department of Regulation and Licensing.

MAC - Monitored anesthesia care.

MEB - State of Wisconsin Medical Examining Board.

PACB - State of Wisconsin Podiatry Affiliated Credentialing Board.

PACU - Post-anesthesia care unit.

RN - Registered nurse.

WSA - Wisconsin Society of Anesthesiologists.

WANA - Wisconsin Association of Nurse Anesthetists.

WSPM - Wisconsin Society of Podiatric Medicine.

[5] See *Wis. Stat. § 806.04*; *22A Am Jur 2d Declaratory Judgments § 1*; *State ex rel. Chiarkas v. Skow*, 160 Wis. 2d 123, 131-132, 465 N.W.2d 625, 628 (1991).

[6] *Wisconsin Fertilizer Ass'n v. Karns*, 39 Wis. 2d 95, 107, 158 N.W. 2d 294, 300 (1968).

[7] *Memorandum of Petitioner in Support of Motion for Summary Judgment*, at 2-5.

- [8] *U.S. Oil Co. v. Midwest Auto Care Services, Inc.*, 150 Wis.2d 80, 86, 440 N.W.2d 825, 827 (Ct. App. 1989).
- [9] 73 Am Jur 2d Summary Judgment § 1
- [10] *Balele v. Wis. Pers. Comm'n*, 223 Wis. 2d 739, 745-46, 589 N.W. 2d 418, 421-22 (Ct. App. 1998).
- [11] Wis. Stat. § 802.08(2); *Green Spring Farms v. Kersten*, 136 Wis. 2d 304, 315, 401 N.W.2d 816, 820 (1987).
- [12] See *Strigenz v. Department of Regulation*, 103 Wis. 2d 281, 286, 307 N.W. 2d 664, 667 (1981); *Laufenberg v. Cosmetology Examining Board*, 87 Wis. 2d 175, 184, 274 N.W.2d 618 (1979).
- [13] *Gilbert v. State Medical Examining Bd.*, 119 Wis. 2d 168, 188, 349 N.W. 2d 68, 76 (1984); *State ex rel. Wis. Registration Bd. of Architects & Professional Engineers v. T. V. Engineers*, 30 Wis.2d 434, 438-39, 141 N.W. 2d 235, 237 (1966).
- [14] Wis. Stat. § 15.01(7) and 15.405 (7) and (7g).
- [15] Wis. Stat. § 15.01(5)(b).
- [16] Wis. Stat. § 227.10(1).
- [17] Wis. Stat. § 440.035(1).
- [18] Wis. Stat. § 440.045.
- [19] "Affiliated credentialing board" is defined in Wis. Stat. § 15.01(1g).
- [20] Wis. Stat. § 15.085(3)(b).
- [21] *Flejter v. Estate of Flejter*, 2000 WI App 26, ¶10, 240 Wis. 2d 401, 409, 623 N.W. 2d 552, 557; *Georgina G. v. Terry M. (In the Interest of Angel Lace M.)*, 184 Wis. 2d 492, 512, 516 N.W.2d 678, 684 (1994).
- [22] Wis. Stat. § 802.08. The procedure utilized for submitting and responding to proposed findings of fact is set forth in the *Second Amended Scheduling Order For Summary Judgment Motion* of July 25, 2006.
- [23] Under Wis. Stat. § 448.01(9) the "practice of medicine and surgery" means:
- (a) To examine into the fact, condition or cause of human health or disease, or to treat, operate, prescribe or advise for the same, by any means or instrumentality.
 - (b) To apply principles or techniques of medical sciences in the diagnosis or prevention of any of the conditions described in par. (a) and in sub. (2).
 - (c) To penetrate, pierce or sever the tissues of a human being.
 - (d) To offer, undertake, attempt or do or hold oneself out in any manner as able to do any of the acts described in this subsection.
- [24] 2001 OAG #1-01; 68 Wis. Op. Att'y Gen. at 319-30 (1979). Overlap between the medical and nursing professions is also discussed in an opinion of the Texas Attorney General, 1999 Tex. AG LEXIS 136.
- [25] 2001 OAG #1-01 10, 11.
- [26] See: Wisconsin Department of Regulation and Licensing. Certification for Advanced Practice Nurses. January 17, 2006. <http://drl.wi.gov/dept/forms/capn.pdf>. (Copied as Appendix A).
- [27] See Exhibit A, Affidavit of Francis Ross Gerbasi of WANA's *Memorandum In Opposition To The Summary Judgment Motion Of The Wisconsin Society of Anesthesiologists*.
- [28] Wis. Stat. § 441.16; Wis. Adm. Code § 8.04. See also: Wisconsin Department of Regulation and Licensing, Advanced Practice Nurse Prescriber – Credentialing, January 18, 2007, <http://drl.wi.gov/prof/nura/cred.htm>; License Lookup Health Professions, January 18, 2006. http://drl.wi.gov/drl/drlookup/LicenseLookupServlet?page=lookup_health.
- [29] Exhibits 10 - 39 to Petitioner's *WSA Exhibits Binder* submitted with Petitioner's *Memorandum Of Petitioner In Support Of Motion For Summary Judgment*.
- [30] The rule specifying collaboration requirements of APNPs, Wis. Adm. Code § N 8.10 (7), was published in the Wisconsin Administrative Register, October, 2000, No. 538, eff. 11-1-00.
- [31] *Wisconsin Administrative Register*, February, 1995, No. 470, eff. 3-1-95.
- [32] See Appendix B. *Wisconsin Administrative Register*, September 1999, No. 525, 18. Moen and Nania letters are copied from the Department of Regulation and Licensing Rulemaking file for CR99-126.
- [33] The legislative history of Clearinghouse Rule 99-126 is available at the Wisconsin Legislature Internet site <http://nxt.legis.state.wi.us/nxt/gateway.dll/?f=templates&fn=default.htm> under "BILL HISTORIES" for the 1999 legislative session.
- [34] *Elections Bd. v. Wisconsin Mfrs. & Commerce*, 227 Wis. 2d 650, 597 N.W.2d 721 (1999); *Schoolway Transp. Co. v. DMV*, 72 Wis. 2d 223, 236-37, 240 N.W.2d 403 (1976); *Frankenthal v. Wisconsin Real Estate Broker's Board*, 3 Wis. 2d 249, 88 N.W.2d 352, reh'g den. 3 Wis. 2d 257A, 89 N.W.2d 825 (1958).
- [35] *Mallo v. Wis. Dep't of Revenue*, 2002 WI 70 ¶30, 253 Wis. 2d 391, 417, 645 N.W.2d 853, 865.
- [36] Wis. Adm. Code § 8.02(1)(b).
- [37] Wis. Adm. Code § N 8.06(1).
- [38] See Exhibits BON-2 (Affidavit of Linda M. Sanner, ¶1.), BON-3, and the "Clinical responsibilities checklist in BON-4.
- [39] *Memorandum Of Petitioner In Support Of Motion For Summary Judgment*, 31-32.
- [40] The BON contends that splitting the authority to prescribe from the authority to administer is impractical and would strain healthcare practice. *Board Of Nursing's Opposition To Petitioner's Motion For Summary Judgment*, 12-13.
- [41] Page G24, Wisconsin Legislative Reference Bureau, Drafting Record for 1993 Wisconsin Act 138, copied under Tab F of the *Memorandum of Petitioner in Support of Motion for Summary Judgment*.
- [42] *Memorandum of Petitioner in Support of Motion for Summary Judgment*, 30-32.
- [43] Page F11, Wisconsin Legislative Reference Bureau, Drafting Record for 1993 Wisconsin Act 138. See Appendix C.
- [44] "Statutory interpretation begins with the language of the statute. If the meaning of the statute is plain, we ordinarily stop the inquiry. Kalal v. Circuit Court for Dane County, 2004 WI 58, P45, 271 Wis. 2d 633, 681 N.W.2d 110. We assign the words in the statute their common, ordinary, and accepted meaning. Id. We also consider the context and structure of the statute. Id., P46. We interpret statutes to avoid absurd or unreasonable results and to give effect to every word in the text." *Olstad v. Microsoft Corp.*, 2005 WI 121, ¶18, 284 Wis. 2d 224, 234, 700 N.W.2d 139, 144.
- [45] A CRNA/APNP is subject to the standards of professional conduct for registered nurses which, if violated, warrant disciplinary action,

including revocation and suspension. These standards prohibit acts which show the registered nurse, to be unfit or incompetent by reason of negligence. Wis. Stat. § 441.07(1)(c). For purposes of discipline the BON has defined "negligence" to mean: "Offering or performing services as a . . . registered nurse for which the licensee is not qualified by education, training or experience." Wis. Adm. Code § N 7.03(1)(intro) and (g). The Board's rules regulating APNPs provide in Wis. Adm. Code § N 8.05(3) that the APNP may "issue only those prescription orders appropriate to the advanced practice nurse prescribers areas of competence, as established by his or her education, training or experience."

[46] *State v. James P. (In re Chezron M.)*, 2005 WI 80, P24-28, 281 Wis. 2d 68 *Wisconsin Citizens Concerned for Cranes and Doves*, 2004 WI 40, 270 Wis. 2d 318, ¶17, 677 N.W.2d 612.

[47] See Stephen R. Miller, Legislative Reference Bureau, Wisconsin Bill Drafting Manual 2.01(1)(i) (2005-06).

[48] Section 80, 2001 Wisconsin Act 107, states:

Section 80. 441.11 (4) of the statutes is renumbered 441.001 (4) (intro.) and amended to read:

441.001 (4) ~~Practice of professional~~ **Professional NURSING.** (intro.) ~~The practice of professional nursing within the terms of this subchapter~~ "Professional nursing" means the performance for compensation of any act in the observation or care of the ill, injured, or infirm, or for the maintenance of health or prevention of illness of others, ~~which act that~~ requires substantial nursing skill, knowledge, or training, or application of nursing principles based on biological, physical, and social sciences, ~~such as the~~. Professional nursing includes any of the following:

(a) ~~The~~ The observation and recording of symptoms and reactions, ~~the~~.

(b) ~~The~~ The execution of procedures and techniques in the treatment of the sick under the general or special supervision or direction of a physician, podiatrist licensed under ch. 448, dentist licensed under ch. 447 or optometrist licensed under ch. 449, or under an order of a person who is licensed to practice medicine, podiatry, dentistry or optometry in another state if ~~that~~ the person making the order prepared the order after examining the patient in that other state and directs that the order be carried out in this state, ~~and the~~.

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

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

The note following section 80 of 2001 Wisconsin Act 107 states:

NOTE: Moves definition section to the beginning of the subchapter, modifies language, and modifies language for improved readability and conformity with current style. The defined terms are changed to reflect the actual terms used in ch. 441. 1981 Wis. Act 317 added the phrase, "Except as provided in s. 50.04 (2) (b), the practice of professional nursing includes", in sub. (4) to exclude activity under that provision from the definition of professional nursing. The amendment of sub. (4) applies the phrase "professional nursing includes" to all of the examples under the subsection for consistency and to avoid possible confusion.

[49] 67 Cal. Op. Att'y Gen. 122, 1984 Cal. AG LEXIS 68.

[50] See responses and replies of the parties to *Petitioner's Proposed Summary Judgment Findings of Fact* ¶12.

[51] The definition of "professional nursing" in section 2725 of the California Nursing Practice Act quoted in the opinion states:

"The practice of nursing within the meaning of this chapter means those functions including basic health care, which help people cope with difficulties in daily living which are associated with their actual or potential health or illness problem or the treatment thereof which require a substantial amount of scientific knowledge or technical skill, and includes all the following:

"(a) Direct and indirect patient care services that insure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures.

"(b) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.

"(c) The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries.

"(d) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (1) determination of whether such signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics; and (2) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures."

[52] 1984 Cal. AG LEXIS 68 at 3.

[53] *Memorandum of Petitioner in Support of Motion for Summary Judgment*, 28.

[54] Wis. Stat. § 441.16(3)(a).

[55] The legislature's findings in Section 1 of Act 37 were summarized in *State ex rel. Strykowski, v. Wilkie*, 81 Wis. 2d 491, 508; 533; 261 N.W.2d 434, 442 (1978).

. . . The legislature cited a sudden increase in the number of malpractice suits, in the size of awards, and in malpractice insurance premiums, and identified several impending dangers: increased health care costs, the prescription of elaborate "defensive" medical procedures, the unavailability of certain hazardous services and the possibility that physicians would curtail their practices. In addition, resolution of a malpractice claim under the traditional tort litigation process has been found to require an average of nineteen months. . . .

[56] The provisions of Wis. Stat. ch. 655 (1975) were unsuccessfully challenged as unconstitutional in *State ex rel. Strykowski v. Wilkie*, 81 Wis. 2d 491, 261 N.W.2d 434 (1978). Although classification issues were raised as an equal protection challenge, the classification of physicians, hospitals and nurse anesthetists as health care providers is not discussed in the opinion. The court concluded generally: "We believe there is a rational basis upon which the legislature could and did act when enacting Chapter 655." *Strykowski*, at 508.

[57] 1993 Wisconsin Act 473.

[58] Current Wis. Stat. § 655.005 was created as Wis. Stat. § 655.004 (1985) by s. 26, 1985 Wisconsin Act 340.

[59] Wis. Stat. §§ 50.32 to 50.39.

[60] Wis. Adm. Code § HFS 124.20(2)(a)4.

[61] Wis. Adm. Code § HFS 124.20(3)(b)3. – 5.

[62] Wis. Stat. § 15.085(3)(b): "The chairperson of an affiliated credentialing board shall meet at least once every 6 months with the examining board to which the affiliated credentialing board is attached to consider all matters of joint interest."

[63] CMS received over 28,500 comments on its proposed anesthesia requirements from hospitals, professional organizations, accrediting bodies, practitioners, and other individuals. 66 Federal Register 219 (13 Nov. 2001), 56703

[64] These findings were developed utilizing summary judgment procedures permitting a party to propose findings of fact and to contest proposed findings made by another party on the basis of admissible evidence. The procedure utilized for submitting and responding to proposed findings of fact is set forth in the *Second Amended Scheduling Order For Summary Judgment Motion* of July 25, 2006. These findings are based on agreement of the parties, the affidavits of Dr. Deborah Rusy and Dr. Brian G. McAlary and the conclusions reached in this decision regarding the responsibility of CRNAs. A proposed factual finding is included despite objections to the proposed finding if the proposed finding is material to the issues, consistent with the legal conclusions in this decision, and no supporting affidavits or other factual evidence is submitted to support the objection.

[65] The words "and prescription" as proposed by Petitioner were deleted from paragraph 3.a. based on the objection of the WANA and the discussion in the opinion regarding the respective authority of a CRNA/APNP and a CRNA not credentialed as an APNP.

[66] Paragraph 12.a. is based on the WANA's objection to Findings '12 – 23 and the affidavit of Dr. Brian G. McAlary, ¶ 5.

[67] Here, and generally, the assertion in the proposed findings submitted by the petitioner that the implementation of the anesthesia plan by a CRNA requires the CRNA to work under the direction of the anesthesiologist or that only an anesthesiologist may perform certain procedures is not included in these findings because the finding may be inconsistent with provisions of Wis. Stat. § 448.03(2)(a) and Wis. Adm. Code § N 8.10 (7) when the person administering the anesthesia is qualified as an APNP/CRNA.

[68] See Note 67.

[69] See Note 67.

[70] See note 67.

[71] See note 67.

[72] See note 65.

[73] See note 65.

[74] See note 65 and Wis. Adm. Code § 124.20(3)(b)5.

[75] See note 65.

PHYSICIAN'S DUTY:
INFORMATION AND ACCESS TO EMERGENCY
CONTRACEPTION

As a regulatory authority, the Wisconsin Medical Examining Board (MEB) is authorized to promulgate rules for the guidance of the members of the medical profession, including the definition and enforcement of standards for unprofessional conduct and unethical practices. At various times, questions or topics involving the professional responsibilities of physicians are presented to the MEB for consideration or clarification. A current topic of legislative interest is that of emergency contraception and the duty of health care providers, including physicians, to provide information and access to such care to victims of sexual assault. The policies of key medical organizations such as the American Medical Association (AMA) encourages physicians and other health care providers to play a more active role in providing education about emergency contraception and writing prescriptions for emergency contraceptives as requested by their patients. AMA Policy Statement: Emergency Contraception, 2005¹

The statutes and rules which govern the practice of medicine in Wisconsin impose a professional obligation on physicians to inform their patients of alternate viable modes of treatment. The statutory provision is found in Wis. Stat. § 448.30, Information on Alternate Modes of Treatment, which states, in pertinent part:

Any physician who treats a patient shall inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments.

The MEB has promulgated Wis. Admin. Code § Med 18.03(1) which specifically requires a physician to communicate alternate viable modes of treatment to a patient. This rule, which was adopted in 1983, states, in pertinent part:

¹The American College of Obstetricians and Gynecologists (ACOG) Legislative Issue Brief, Access to Emergency Contraception, 2007, supports and promotes measures and strategies to increase women's awareness and knowledge of emergency contraception and their ability to access emergency contraception without costly delays or the imposition of geographic, financial, attitudinal or legal barriers.

It is the obligation of a physician to communicate alternate viable modes of treatment to a patient. The communication shall include the nature of the recommended treatment, alternate viable treatments, and risks or complications of the proposed treatment sufficient to allow the patient to make a prudent decision.

The failure to inform a patient about the availability of all alternate viable medical modes of treatment is also included in the definition of unprofessional conduct in Wis. Admin. Code § Med 10.02(2)(u). Although the statute and rule allow for exceptions to the physician's duty to communicate alternate modes of treatment, these exceptions are exclusively patient-based and take into consideration the patient's condition and interest in obtaining appropriate health care treatment.² This is consistent with language in the administrative rule with respect to the duty to communicate to the patient:

In the communication with a patient, a physician shall take into consideration:

- (a) A patient's ability to understand the information;*
- (b) The emotional state of a patient; and*
- (c) The physical state of the patient.*

The physician's duty to communicate is particularly critical in situations where the provision of the information to the patient is time sensitive. In an emergency medical situation involving sexual assault if

² The administrative rule provides that nothing in the sub. (1) shall be construed as preventing or limiting a physician in recommending a mode of treatment which is in his or her judgment the best treatment for a patient. Wis. Admin. Code § Med 18.03(2). The physician's discretion with respect to the communication of alternate modes of treatment is further defined in Wis. Admin. Code § Med 18.04 which states that a physician is not required to explain each procedural or prescriptive alternative inherent to a particular mode of treatment. Nor is the physician held responsible for failure to inform a patient of possible complications or benefits not generally known to a reasonably well-qualified physicians in a similar medical classification. The rule also provides that the physician may not be held responsible for failure to communicate alternate modes of treatment to a patient if failure to provide immediate treatment would be more harmful to a patient than immediate treatment, would unduly confuse or frighten the patient, or if a patient refuses to receive the communication.

a physician fails to communicate an alternate mode of treatment, such as emergency contraception, in a timely manner the option or efficacy of the treatment could be compromised or irretrievably lost. Thus, the standard of care requires that a physician provide information on treatment alternatives in sufficient time so that the patient could make a prudent choice whether or not to accept the treatment. In addition, should the patient request emergency contraception, the physician must either provide such treatment or make a reasonable effort to facilitate patient access to such treatment without placing an undue burden on the patient and in a time frame which reflects the urgency of the situation.³ By failing to provide the sexual assault victim with timely information about emergency contraception, and when requested treatment or facilitation of such treatment a physician may be found to have departed from the standard of care ordinarily exercised by a minimally competent physician and engaged in a practice which constitutes a danger to the health safety and welfare of a patient in violation of Wis. Admin. Code §§ Med 10.02(2)(h), 10.02(2)(u) and 18.03, and may be subject to discipline for unprofessional conduct.

³ The Board does not endorse the physician's refusal to facilitate patient access to emergency contraception for personal reasons but does recognize the occasional need for referral due to logistical barriers.

Medical Examining Board Update-Important Changes in WI Law

June 2, 2010

On May 18th, Governor Doyle signed AB 877 into law as 2009 WI Act 382. This act, initiated by the Medical Examining Board (MEB) will be reviewed in detail in the Regulatory Digest to be published in July. This act makes a number of changes to Wisconsin law.

- * The act places a legal duty upon all licensed physicians (MD and DO) to report other physicians to the MEB under circumstances detailed in the law.
- * The prescribing limitation on residents working under a Temporary Educational Permit is eliminated.
- * Changes are made to the MEB process for issuing summary license suspensions.
- * The MEB is granted the ability to change Continuing Medical Education requirements by rule rather than by legislation.

The intent of the new law is to protect of patients and the public. This bill was initiated by the MEB in an effort to improve our ability to protect the public from physicians who may pose a threat to their patients. The duty to report codifies ethical obligations which exist in policy statements of the Wisconsin Medical Society and American Medical Association and creates a duty similar to what exists in the laws of many other states. It was created with the knowledge that physicians are in the best position to be aware of colleagues who may engage in a pattern of unprofessional conduct; engage in acts creating an immediate or continuing danger to patients or the public; may be medically incompetent; or may be mentally or physically unable to safely practice medicine. Failure to report such physicians may under the law lead to discipline by the MEB.

This law applies to all licensed physicians without exclusion and thus, we realize, may create a conflict for some physicians, particularly those engaged in medical management/peer review and those physicians treating other physicians for psychiatric and substance abuse problems. Complete guidance will be forthcoming on these issues.

Reports should be made to the Wisconsin Department of Regulation and Licensing (DRL), in writing and contain sufficient detail to allow appropriate investigation. Information on how to file a complaint is available on the DRL website at www.drl.wi.gov. The filing of a complaint does not automatically result in a disciplinary action. Actions by the MEB are judicial in nature and respondents (those reported) have full rights to due process before any adverse action may be taken against them. The full text of 2009 WI Act 382 can be found on-line at: <http://www.legis.state.wi.us/2009/data/acts/09Act382.pdf>

Sincerely,

Dr. Sujatha Kailas
Chair-Medical Examining Board

Dr. Gene Musser
Immediate Past Chair-Medical Examining Board

Medical Examining Board of the State of Wisconsin
Position Statement on Pain Management

The mission of The Medical Examining Board is to promote and protect the health and welfare of the citizens of the State of Wisconsin by fostering the provision of safe and competent medical care. The Board recognizes that such care involves the provision of appropriate and effective management of pain.

The under treatment of pain continues to be a significant public health problem in the United States. Inadequate pain control may result from physicians' lack of knowledge about pain assessment and management and/or their misunderstanding of the safety and efficacy of opioid analgesics, drugs that are essential for the management of moderate to severe pain. Physicians may also fear investigation or sanction by federal, state and local agencies which may lead to inappropriate treatment of pain.

The Board encourages physicians to view effective pain assessment and management as part of quality medical care for all patients with pain, whether it is acute or chronic. It is especially important for patients who are experiencing pain at the end of life. All physicians should be knowledgeable about effective methods of pain assessment and treatment as well as the statutory requirements for prescribing controlled substances. The medical management of pain should be guided by current knowledge and acceptable medical practice, which includes the use of both pharmacologic and non-pharmacologic modalities. Pain should be assessed and treated promptly and appropriately with clear documentation.

The Board recognizes that opioid analgesics are subject to abuse by individuals who seek them for mood altering and other psychological effects rather than for legitimate medical purposes. Physicians who use these drugs in the course of treatment should be diligent and incorporate established safeguards into their practices to minimize the potential for their diversion and abuse.

The Board further recognizes that tolerance and physical dependence are normal consequences of the sustained use of opioid analgesics and are not synonymous with psychological dependence (addiction). Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial and environmental factors influencing its development and manifestations. It is characterized by behaviors that include: impaired control over drug use, craving, compulsive use, and continued use despite harm. Persons with a history of drug abuse have the right to appropriate pain management, even if opioids must be used. Such persons may require specialized care. Tolerance may occur but it is not an inevitable consequence of chronic opioid therapy. Physical dependence is a normal and predictable state of adaptation to a drug, and by itself, does not equate with addiction.

Physicians should not fear disciplinary action from the Board for administering controlled substances, including opioid analgesics, for a legitimate medical purpose in the usual course of professional practice. The Board will initially consider the use of controlled substances for the treatment of pain to be for a legitimate medical purpose based on accepted scientific knowledge of the treatment of pain, patient clinical presentation and sound clinical

judgment. Proper written documentation, the patient's medical condition and clinical response to treatment provide strong foundations for verifying optimal patient care, if review of the patient record is necessitated at some future time.

The Medical Examining Board of the State of Wisconsin is adopting and disseminating this position statement to support and encourage safe, competent, and high quality medical care for persons with pain. By so doing, the Board clearly communicates to physicians that it:

- 1) encourages safe and effective pain management practices
- 2) recognizes that pain management, which may involve the use of opioid analgesics, is a critical part of medical practice
- 3) will not sanction physicians solely for providing opioid analgesics provided the physician administers the medication in a safe and effective manner in compliance with state and federal law.

Position statement developed in collaboration with the WI Pain Initiative, 1300 University Avenue, Madison, WI <http://aspi.wisc.edu/wpi/>

POSITION PAPER

EXPEDITED PARTNER THERAPY FOR SEXUALLY TRANSMITTED DISEASES

- The Wisconsin Medical Examining Board (MEB) recognizes that the adequate treatment of sexually transmitted diseases (STDs), such as gonorrhea and chlamydia infections, is an important public health issue.
- The MEB recognizes that physicians and other health-care providers play a critical role in preventing and treating STDs.
- The MEB recognizes that adequate treatment and prevention of these infectious diseases often depends on the treatment of the partner(s) of a patient who may not be available or agreeable to direct examination by the physician.
- The MEB further recognizes that it has been common practice for physicians to provide antibiotics for the partner(s) of a patient with an STD without prior clinical examination of the partner, and while this practice is not ideal in terms of diagnosis and prescriptive practice, it is often the only realistic way to reduce the incidence of reoccurrence and transmission of the diseases.
- The United States Centers for Disease Control and Prevention (CDC) has recommended an emerging alternative to traditional partner management for STDs which involves the delivery and prescription of medications to STD patients for their partners without the clinical assessment of the partners. The CDC issued treatment guidelines in 2006 for this form of practice which is known as the "Expedited Partner Therapy" (EPT).
- The American Medical Association has endorsed the practice of EPT as applied to chlamydia and gonorrhea infections. (June 2006)
- The Wisconsin Division of Health and Family Services has also adopted regulations for Sexually Transmitted Diseases Treatment which reference and incorporate the CDC treatment guidelines for EPT. HFS § 145.22, Wis. Admn. Code
- The practice of EPT in accordance with the CDC guidelines may constitute the standard of care with respect to the treatment of STDs of patients with absent partners to reduce the incidence of reoccurrence and transmission of the diseases.
- Given that the public risk of untreated STDs is greater than the risk of complications from dispensing in this less than ideal setting, the MEB recognizes the CDC guidelines for the practice of EPT and supports the passage of legislative authority to expressly authorize the provision of EPT treatment by licensed physicians in Wisconsin.

- Accordingly, until such legislative authority is secured, the MEB recommends that physicians use all reasonable measures available to ensure that appropriate treatment is made available to the patient's partners. These measures may include offers for low-cost or no-cost examination by the physician of the patient or the referrals to other providers in the community that may offer such services. If an examination of the patient's partner(s) is not feasible, the physician could choose to follow the CDC guidelines as well as other applicable prescription labeling. For example, the prescription label should include the patient's own name and the partner(s) name or, if unknown, the patient's name followed by the word "partner." The physician should also assign a separate and unique identifying number to each prescription and clearly identify this number on each corresponding prescription label. The physician should follow appropriate health care record-keeping and provide advice and direction to the patient's partner(s) for use of the medications, including adverse reactions, complications and the need for follow-up care. These recommendations may serve as a course of clinical guidance; however each physician or health care provider should always consider the individual clinical circumstances of each person in the context of local disease prevention.



EXECUTIVE ORDER # 50

Relating to Guidelines for the Promulgation of Administrative Rules

WHEREAS, 2011 Wisconsin Act 21 reformed the administrative rulemaking process in Wisconsin in order to increase accountability, clarify agency regulatory authority, and evaluate the economic impact of all new and amended state administrative rules; and

WHEREAS, Wis. Stat. § 227.10(1) requires that each agency statement of policy and each interpretation of a statute adopted to govern its enforcement or administration of that statute shall be promulgated as a rule, and Wis. Stat. § 227.01(13) defines a rule as “a regulation, standard, statement of policy or general order of general application which has the effect of law and which is issued by an agency to implement, interpret or make specific legislation enforced or administered by the agency or to govern the organization or procedure of the agency;” and

WHEREAS, Wis. Stat. § 227.10(2m) requires an explicit grant of authority under statute or administrative rule before a state agency can implement or enforce any standard, requirement, or threshold, including as a term or condition of any license issued by the agency; and

WHEREAS, Wis. Stat. §§ 227.11(2)(a)1. to 3. defines agency authority to promulgate administrative rules, specifically providing the following:

- A statutory or nonstatutory provision containing a statement or declaration of legislative intent, purpose, findings, or policy does not confer rulemaking authority on the agency or augment the agency’s rulemaking authority beyond the rulemaking authority that is explicitly conferred on the agency by the legislature.
- A statutory provision describing the agency’s general powers or duties does not confer rulemaking authority on the agency or augment the agency’s rulemaking authority beyond the rulemaking authority that is explicitly conferred on the agency by the legislature.
- A statutory provision containing a specific standard, requirement, or threshold does not confer on the agency the authority to promulgate, enforce, or administer a rule that contains a standard, requirement, or threshold that is more restrictive than the standard, requirement, or threshold contained in the statutory provision; and

WHEREAS, Wis. Stat. §§ 227.135(2), 227.24(1)(e)1d. requires the Governor to approve a statement of scope before an agency may proceed with rulemaking, Wis. Stat. § 227.185 requires the Governor to approve a final draft rule before it is submitted to the Legislature for review, and Wis. Stat. § 227.24(1)(e)1g. requires the Governor to approve an emergency rule before it is filed with the Legislative Reference Bureau and published in the official state newspaper; and

WHEREAS, Wis. Stat. § 227.137 requires state agencies to complete an Economic Impact Analysis (EIA) for every proposed rule in coordination with local governmental units that may be affected and to solicit information and advice from and consult with businesses,

associations representing businesses, local governmental units and individuals that may be affected by the proposed rule; and

WHEREAS, Wis. Stat. § 227.10(2m) establishes that “[t]he Governor, by executive order, may prescribe guidelines to ensure that rules are promulgated in compliance with [Subchapter II of Chapter 227 of the Wisconsin Statutes].”

NOW THEREFORE, I, Scott Walker, Governor of the State of Wisconsin, by virtue of the authority vested in me by the Constitution and the laws of Wisconsin, specifically Wis. Stat. § 227.10(2m), do hereby direct that state agencies shall comply with the requirements of Subchapter II of Chapter 227 and this Executive Order when promulgating administrative rules.

I. General Provisions

1. To assure timely and proficient review of administrative rules in accordance with this Executive Order and with Wis. Stat. § 227.10(2m), the Governor’s Office of Regulatory Compliance is hereby established.
2. Each agency that develops any document interpreting, clarifying, or explaining statutes and rules that regulate individuals or entities or local governmental units, shall submit a copy to the Governor’s Office of Regulatory Compliance via AdministrativeRules@Wisconsin.gov prior to its finalization by that agency.
3. Each agency shall submit to the Governor’s Office of Regulatory Compliance all materials required to be submitted under Subchapter II of Chapter 227. This includes all publicly available materials submitted to the Legislative Council Rules Clearinghouse, Legislative Reference Bureau, Department of Administration, Chief Clerks of the State Assembly and State Senate, legislative standing committees, and the Joint Committee for Review of Administrative Rules.
4. The electronic submission of materials to the State Budget Office, via SBOAdminRules@wisapps.wi.gov or as the State Budget Office otherwise prescribes, shall fulfill an agency’s duty, under Chapter 227 and Paragraph I.3. of this Executive Order, to submit materials to the Governor, the Governor’s Office of Regulatory Compliance, or the Department of Administration.
5. Each statement of scope submitted by an agency on or after June 8, 2011 is subject to review and approval by the Governor as required by Wis. Stat. §§ 227.135(2), 227.24(1)(e)1d. and Paragraph II.1. of this Executive Order. An EIA shall be prepared as required by Wis. Stat. § 227.137 and Paragraph IV.1. of this Executive Order if the draft rule is submitted to the Legislative Council Rules Clearinghouse under Wis. Stat. § 227.15 on or after June 8, 2011. An EIA is not required when an agency promulgates an emergency rule. A final draft rule or emergency rule is subject to review and approval by the Governor, as required by Wis. Stat. §§ 227.185, 227.24(1)(e)1g. and Paragraph V.1. of this Executive Order, if the statement of scope for the rule or emergency rule was submitted on or after June 8, 2011.
6. The language of Wis. Stat. § 990.001(11) concerning severability and Wis. Stat. § 990.01 concerning construction of words and phrases are intended to apply to this Executive Order.

II. Statements of Scope

1. A statement of scope shall be submitted to the Governor’s Office of Regulatory Compliance for approval by the head of the agency proposing a rule or emergency rule or by a deputy or executive assistant who has been authorized to do so by the agency head under Wis. Stat. §§ 15.04(2) or 15.05(3). Statements of scope shall be submitted electronically, as prescribed in Paragraph I.4. of this Executive Order, and contain the following information as required by Wis. Stat. § 227.135(1).
 - a. A detailed description of the objective of the rule.

- b. A detailed description of existing policies relevant to the rule and new policies proposed to be included in the rule and an analysis of policy alternatives. The description shall include an overview of the requirement or program that the rule will implement. If the proposed rule will amend an existing rule, the description shall also include an overview of the existing rule and the general changes. If the proposed rule will replace an emergency rule currently in effect, the agency shall summarize the status of any legislative action under Wis. Stat. § 227.24(2) or § 227.26(2) and identify any implementation issues that have arisen since the rule was promulgated.
 - c. A detailed description of the statutory authority for the rule. The agency shall reference each statute that authorizes the promulgation of the proposed rule and each statute or rule that will affect the proposed rule or be affected by it. The agency shall also explain in detail the agency's authority to promulgate the proposed rule under those statutes. An agency shall rely on an explicit grant of authority from the Legislature to promulgate a rule, if one exists. An agency shall not rely upon general statements of legislative purpose or legislative findings or agency general powers and duties clauses to confer authority to promulgate rules. Pursuant to Wis. Stat. § 227.11(2)(a), in the absence of an explicit grant of rulemaking authority, an agency may promulgate a rule if:
 - i. The agency considers it necessary to effectuate the purpose of the statute; and
 - ii. The agency has a general grant of rulemaking authority to administer or enforce the chapter, subchapter, or section of the Wisconsin statutes.
 - d. An estimate of the amount of time that state employees will spend to develop the rules and of other resources necessary to develop the rule.
 - e. A description of all of the entities that may be affected by the rule. This includes a description of any local governmental units, businesses, economic sectors, or public utility ratepayers who may reasonably be anticipated to be affected by the rule.
 - f. A summary and preliminary comparison, with state law, of any existing or proposed federal regulation that is intended to address the activities to be regulated by the rule.
2. A statement of scope shall also include a statement of whether the agency anticipates that the proposed rule will have minimal or no economic impact, may have a moderate economic impact, or is likely to have a significant economic impact locally or statewide.
 3. A statement of scope for a proposed emergency rule shall also include an explanation of why the rule is necessary for the preservation of the public peace, health, safety, or welfare. If the rule is exempt from the required finding of emergency, the statement of scope shall cite the Wisconsin Act number and section authorizing the promulgation of an emergency rule or the statute section providing the exemption. The statement of scope shall also indicate whether the agency will promulgate a non-emergency rule and when it will begin the non-emergency rulemaking process.
 4. An agency that intends to simultaneously draft an emergency and a non-emergency rule that are identical in substance may submit one scope statement indicating this intent.
 5. Pursuant to Wis. Stat. § 227.135(2), no state employee may begin work on a proposed rule or emergency rule until the statement of scope has been approved by the Governor, published in the Administrative Register, and approved by the agency head or body with policy making powers for the agency.
 6. A statement of scope not submitted in accordance with Wis. Stat. § 227.135(1) and this Executive Order will be returned to the agency and the Governor's Office of

Regulatory Compliance's review will be suspended until a complete description and analysis is resubmitted.

7. The Governor's Office of Regulatory Compliance may request an agency to withdraw a statement of scope and resubmit separate statements of scope if, in the Governor's discretion, the original statement of scope encompasses more than one rule change.
8. Following a review of the statement of scope, the Governor's Office of Regulatory Compliance shall notify the agency in writing whether the statement of scope is approved or disapproved. A disapproval by the Governor may be accompanied by suggested modifications in the event an agency chooses to submit a revised statement of scope.
9. An agency must file a statement of scope approved by the Governor for publication by the Legislative Reference Bureau within thirty calendar days of approval if the agency intends to proceed with rulemaking, or the Governor's Office of Regulatory Compliance will deem the statement of scope to be withdrawn.
10. If at any time during the rulemaking process prior to final approval by the Governor, the scope of a proposed rule is changed in any meaningful or measureable way, including changing the scope so as to include any activity, business, material or product that is not specifically included in the original statement of scope under Wis. Stat. § 227.135(4), a revised statement of scope shall be submitted to the Governor's Office of Regulatory Compliance for approval. A meaningful or measurable change includes a change to the following:
 - a. The objectives of the proposed rule;
 - b. The basis and purpose of the proposed rule;
 - c. The policies to be included in the proposed rule;
 - d. The entities affected by the proposed rule; or
 - e. The overall breadth or scope of the regulation in the proposed rule.
11. If at any time following the Governor's approval of a statement of scope, prior to the submission of a final draft rule to the Legislature for review, the Governor's Office of Regulatory Compliance requests a revised statement of scope from the agency because the rule has been changed in a meaningful or measureable way under Wis. Stat. § 227.135(4), the agency shall submit the revised statement of scope to the Governor's Office of Regulatory Compliance electronically as prescribed in Paragraph I.4. of this Executive Order within fourteen calendar days of receiving the request.

III. Additional Agency Actions in the Rule-Making Process

1. If an agency intends to establish an advisory committee under Wis. Stat. § 227.13, it shall provide a list of members to the Governor's Office of Regulatory Compliance via AdministrativeRules@Wisconsin.gov prior to establishing the advisory committee.
2. The agency's draft rule analysis required under Wis. Stat. § 227.14(2) shall be submitted to the Governor's Office of Regulatory Compliance electronically, as prescribed in Paragraph I.4. of this Executive Order, upon completion and prior to finalization and submittal to the Legislative Council under Wis. Stat. § 227.15(1). In accordance with Wis. Stat. § 227.14(2m), the agency shall include a statement within the analysis describing how the requirements for ensuring the accuracy, integrity, objectivity and consistency of data were used in preparing the proposed rule and related analysis.

IV. Economic Impact Analysis

1. For each proposed rule that is not an emergency rule, an Economic Impact Analysis (EIA) shall be submitted to the Legislative Council, the Governor, the Department of Administration, and the Legislature by the head of the agency proposing a rule as required by § 227.137(4). An EIA shall be submitted electronically to the

Governor's Office of Regulatory Compliance as prescribed in Paragraph I.4. of this Executive Order and this submission shall also fulfill the requirement under § 227.137(4) to submit the EIA to the Governor and the Department of Administration.

2. Prior to initiating an EIA of a proposed rule, the agency shall review the statement of scope to determine whether it was changed in any meaningful or measureable way, under Wis. Stat. § 227.135(4) and Paragraph II.10. of this Executive Order, while the rule was being developed. If a meaningful or measurable change has been made, the agency shall revise and resubmit the statement of scope for approval as required by Wis. Stat. § 227.135(4) and Paragraph II.10. of this Executive Order.
3. In preparing an EIA, under Wis. Stat. § 227.137(3), the agency shall solicit information and advice from businesses, business sectors, associations representing business, local governmental units, and individuals that may be affected by the proposed rule by making information about the rule available and requesting comments.
 - a. Information including the proposed rule language shall be made available by posting on the agency website and the Wisconsin administrative rules website, submitting the information to the Governor's Office of Regulatory Compliance, as prescribed in Paragraph I.4. of this Executive Order, and by e-mailing individuals who have requested to receive information and other persons identified by the agency as potentially interested parties.
 - b. The agency shall accept comments for a period of at least fourteen calendar days if the statement of scope indicates that the draft rule will have no or minimal economic impact locally or statewide, at least thirty calendar days if the statement of scope indicates a moderate economic impact locally or statewide and at least sixty calendar days if the statement of scope indicates that the draft rule may or is likely to have a significant economic impact locally or statewide or on a sector of the economy. If the agency determines that the anticipated economic impact will be greater than indicated in the statement of scope, it shall adjust the comment period accordingly and a revised statement of scope is not required. If an agency determines that the anticipated economic impact will be less than indicated in the statement of scope, it may adjust the comment period accordingly and a revised statement of scope is not required.
 - c. The agency shall review the comments received and the statement of scope description of all of the persons that may be affected by the proposed rule. The agency shall update the list of businesses, business sectors, associations representing businesses, local governmental units, and individuals included in the statement of scope and submit the list to the Governor's Office of Regulatory Compliance via AdministrativeRules@Wisconsin.gov.
4. After soliciting information and advice from businesses, business sectors, associations representing business, local governmental units, and individuals that may be affected by the proposed rule, the agency shall prepare the EIA in coordination with the local governmental units that respond to the agency's solicitation of comments and request to coordinate with the agency, as required by Wis. Stat. § 227.137(3). The agency shall contact those local governmental units to discuss such comments and incorporate them into the EIA to the extent feasible. The agency may at the same time consult with the local governmental units about whether the proposed rule would adversely affect in any material way the economy, a sector of the economy, productivity, jobs or the overall economic competitiveness of the state as required by Wis. Stat. § 227.137(3)(e) and Paragraph IV.3. of this Executive Order.
5. After soliciting information and advice from businesses, business sectors, associations representing business, local governmental units, and individuals that may be affected by the proposed rule, the agency shall make a determination in the EIA as required by Wis. Stat. § 227.137(3)(e), in consultation with those businesses, business sectors, associations representing businesses, local governmental units, and individuals as to whether the proposed rule would adversely affect in a material way

the economy, a sector of the economy, productivity, jobs, or the overall economic competitiveness of this state in the following manner:

- a. The agency shall compile a list of affected persons and economic concerns identified in the comments solicited by the agency.
 - b. The agency shall contact those affected persons to discuss economic concerns and give consideration to those concerns in its EIA determination.
 - c. The agency shall document in the EIA the affected persons who were consulted and whether the agency's determination is disputed by any of the affected persons.
6. For purposes of developing an EIA for a proposed rule that is anticipated to have a significant economic impact locally or statewide, or on a sector of the economy, agencies are encouraged to establish an advisory committee of affected persons following its solicitation of comments in order to coordinate with local governmental units and consult with other affected persons. An agency that previously established an advisory committee under Wis. Stat. § 227.13 to advise it during rulemaking, including the development of the EIA, shall add to the committee affected persons, identified following the agency's solicitation of comments, who wish to serve on the committee.
7. The final EIA shall contain the following information as required by Wis. Stat. § 227.137 on the economic impact of the proposed rule on specific businesses, business sectors, public utility ratepayers, local governmental units, and the state's economy as a whole:
- a. An analysis and quantification of the policy problem that the proposed rule is intending to address, including comparisons with approaches used by the federal government and by Illinois, Iowa, Michigan, and Minnesota to address the policy problem and, if the approach chosen by the agency to address that policy problem is different from those approaches, a statement as to why the agency chose a different approach.
 - b. An analysis and detailed quantification of the economic impact of the proposed rule, including the implementation and compliance costs that are reasonably expected to be incurred by the businesses, local government units, and individuals that may be affected by the proposed rule. A summary of comments related to the implementation and compliance costs received by businesses, local governmental units, and individuals shall be included in the final analysis.
 - c. An analysis of the actual and quantifiable benefits of the proposed rule, including an assessment of how effective the proposed rule will be in addressing the policy problem that the rule is intended to address.
 - d. An analysis of the alternatives to the proposed rule including the alternative of not promulgating the proposed rule.
 - e. A determination made in consultation with the businesses, local governmental units, and individuals that may be affected by the proposed rule as to whether the proposed rule would adversely affect in a material way the economy, a sector of the economy, productivity, jobs, or the overall economic competitiveness of this state. Included in the final analysis shall be a summary of comments related to whether the proposed rule would adversely affect, in a material way, the economic competitiveness of this state received by businesses, local governmental units, and individuals.
 - f. If the agency finds that a proposed rule will not have an economic effect on public utilities or their ratepayers, it shall state this conclusion in the EIA. If the agency finds that a proposed rule will have an economic impact on public utilities or their ratepayers or both, it shall request the information necessary from the Public Service Commission to provide an estimate of the increased costs or resulting savings for public utilities and their ratepayers.

- g. Pursuant to Wis. Stat. § 227.137(3)(f), if an EIA relates to a rule of the Department of Safety and Professional Services establishing standards for dwelling construction, the EIA shall address whether the rule would increase the cost of constructing or remodeling the dwelling by more than \$1,000.
8. If the agency finds that a proposed rule will not have an economic impact after a review of comments submitted in response to the agency's solicitation, it may complete the EIA without additional coordination with local governmental units or consultation with other affected parties. The agency shall detail in the EIA the information supporting the conclusion that the proposed rule will not have an economic impact.
9. If at any time after the final EIA is submitted under Wis. Stat. § 227.137(4) and before the final draft rule is submitted to the Governor's Office of Regulatory Compliance for an approval, the economic impact of the proposed rule is significantly changed, a revised EIA shall be submitted to the Legislative Council, the Legislature, the Department of Administration, and the Governor, as required by under Wis. Stat. § 227.137(4).
- a. A significant change includes an increase or a decrease of at least 10 percent or \$50,000, whichever is greater, in the estimated compliance costs reasonably expected to be incurred by a majority of the businesses, business sector, local governmental units, or individuals that may be affected by the proposed rule or a significant change in the persons affected by the proposed rule.
- b. If in addition to a significant change in the economic impact of the proposed rule, there is also a meaningful or measurable change in the scope of the rule, the agency shall prepare a revised statement of scope and submit it to the Governor's Office of Regulatory Compliance for approval as required by Wis. Stat. § 227.135(4) and Paragraph II.10. of this Executive Order. If a revised statement of scope is approved by the Governor, published in the Administrative Register and approved by the agency head or body with policy making powers for the agency, the agency shall prepare the revised EIA in accordance with Wis. Stat. § 227.137 and Paragraph IV.9. of this Executive Order.
- c. If a revised statement of scope is not required because the scope of the proposed rule has not changed in a meaningful or measurable way, the agency may proceed with the development of the revised EIA using the list of businesses, business sectors, local governmental units, and individuals affected by the proposed rule developed following the agency solicitation of information and advice under Wis. Stat. § 227.137(3) and Paragraph IV.3. of this Executive Order. The agency shall comply with the remaining requirements of Wis. Stat. § 227.137 and this Executive Order.
10. If at any time after the final EIA is submitted under Wis. Stat. § 227.137(4), the Governor's Office of Regulatory Compliance requests a revised EIA because the economic impact of the proposed rule has significantly changed under Wis. Stat. § 217.137(4) and Paragraph IV.9. of this Executive Order, the agency shall submit the revised EIA electronically as prescribed in Paragraph I.4. of this Executive Order within ninety calendar days of receiving the request.
11. If the final EIA submitted under Wis. Stat. § 227.137(4) indicates that a total of \$20,000,000 or more in implementation and compliance costs are reasonably expected to be incurred or passed along to businesses, local governmental units and individuals as a result of the proposed rule, the Department of Administration shall review the rule and issue a report under Wis. Stat. § 227.137(6). Any cost savings identified in the analysis of actual and quantifiable benefits as required by Wis. Stat. § 227.137(3)(c) shall not reduce the total estimated implementation and compliance costs for purposes of determining whether the Department of Administration shall issue a report under Wis. Stat. § 227.137(6).
12. If the Department of Administration is required to complete a report under Wis. Stat. § 227.137(6), an agency shall not submit a proposed rule to the legislature for review under § 227.19(2) until the report has been received.

13. If an agency makes modifications to a proposed rule following the agency public hearing, the agency shall review the rule to determine whether the scope has been changed in any meaningful or measurable way under Wis. Stat. § 227.135(4) and Paragraph II.10. of this Executive Order and whether the economic impact of the proposed rule is significantly changed under Wis. Stat. § 227.137(4) and Paragraph IV.9. of this Executive Order.
 - a. The agency shall notify the Governor's Office of Regulatory Compliance via AdministrativeRules@Wisconsin.gov if it will submit a revised statement of scope to the Governor's Office of Regulatory Compliance for approval or a revised EIA to the Governor's Office of Regulatory Compliance, the Department of Administration, the Legislative Council Rules Clearinghouse and the Legislature, or both a revised statement of scope and a revised EIA. A revised statement of scope shall be submitted to the Governor's Office of Regulatory Compliance electronically as prescribed in Paragraph I.4. of this Executive Order within seven calendar days of the notification.
 - b. If neither a revised statement of scope nor a revised EIA is required, the agency shall submit the final draft rule to the Governor's Office of Regulatory Compliance for approval within thirty calendar days of the close of the public comment period following the public hearing if it intends to proceed with rulemaking, unless the agency has a policy making board that is required to approve the final rule language before it is submitted to the Governor's Office of Regulatory Compliance.

V. Final Draft Rule

1. A final draft rule shall be submitted electronically as prescribed in Paragraph I.4. of this Executive Order to the Governor's Office of Regulatory Compliance for approval by the head of the agency proposing a permanent or emergency rule or by a deputy or executive assistant who has been authorized to do so by the agency head under Wis. Stat. §§15.04(2) or 15.05(3).
2. For each non-emergency rule, the final draft rule submitted to the Governor's Office of Regulatory Compliance shall contain the following information:
 - a. The documents required under Wis. Stat. § 227.15(1), with any necessary updates;
 - b. A statement describing how the rule complies with any applicable requirement under Wis. Stat. § 227.116;
 - c. The final EIA required under Wis. Stat. § 227.137(2);
 - d. The report of the Department of Administration if required under Wis. Stat. § 227.137(6);
 - e. Any energy impact report completed under Wis. Stat. § 227.117(2), and a statement describing the agency's consideration of the energy impact report in accordance with Wis. Stat. § 227.117(3);
 - f. The report of the Small Business Regulatory Review Board required under Wis. Stat. § 227.14(2g);
 - g. Any regulatory flexibility analysis completed under Wis. Stat. § 227.114;
 - h. A list of persons who appeared or registered for or against the rule at the hearing;
 - i. A summary of public comments to the proposed rule and the agency's response to those comments;
 - j. An explanation of any modifications made in the proposed rule as a result of public comments or testimony received at the public hearing; and
 - k. The Legislative Council Rule Clearinghouse report completed under Wis. Stat. § 227.15 and the agency's response to the report as required by Wis. Stat. § 227.19(3)(d).
3. For each emergency rule, the final draft rule submitted to the Governor's Office of Regulatory Compliance shall contain the following information:
 - a. A fiscal estimate in the format required by Wis. Stat. § 227.14(4); and

- b. A plain language analysis of the rule in the format required under Wis. Stat. § 227.14(2).
4. Following a review of the final draft rule, the Governor's Office of Regulatory Compliance shall notify the agency in writing whether the rule is approved or disapproved. A disapproval may be accompanied by suggested modifications. The agency may submit a revised rule for approval under the statement of scope that was previously approved by the Governor.



By the Governor:

Douglas La Follette
DOUGLAS LA FOLLETTE
Secretary of State

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Wisconsin to be affixed. Done at the Capitol in the City of Madison this second day of November, in the year two thousand eleven.

Scott Walker

SCOTT WALKER
Governor

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Gene Musser		2) Date When Request Submitted:	
		Items will be considered late if submitted after 4:30 p.m. and less than: • 10 work days before the meeting for Medical Board • 14 work days before the meeting for all others	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: January 16, 2013	5) Attachments: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6) How should the item be titled on the agenda page? ACGME Post Graduate Education Requirement	
7) Place item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing?	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Wisconsin has a one year post-graduate (residency) training requirement. Dr. Musser asked that the Board discuss this, and Dr. Wasserman asked that it be scheduled for this meeting.			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Gene Musser		2) Date When Request Submitted: <div style="border: 1px solid black; padding: 2px; font-size: small;"> Items will be considered late if submitted after 4:30 p.m. and less than: ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others </div>	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: January 16, 2013	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Duties to Report Professional Misconduct	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? 	9) Name of Case Advisor(s), if required: 	
10) Describe the issue and action that should be addressed: 1. Various entities are required to report misconduct to the Board as a matter of law. Dr. Musser will lead a discussion about the reporting requirements, compliance with the requirements, and the January 2012 Office of Inspector General Report finding that Hospital Incident Reporting Systems Do Not Capture Most Patient Harm, OEI-06-09-00091.			
11) Authorization			
Signature of person making this request			Date
Supervisor (if required)			Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date



News & Views

Citizen Advocacy Center

Third Quarter, 2012 A Health Care Public Policy Forum Volume 24 Number 23

Save The Dates!

Citizen Advocacy Center's 2013 annual meeting will be held in Seattle, Washington, on Tuesday and Wednesday, October 29-30, 2013.

CAC is now a membership organization and we invite your board to join. More information is at <http://www.cacenter.org/cac/membership>.

Although we encourage you to receive our newsletter by becoming a CAC member, you may still subscribe to our newsletter without becoming a member. More information is at <http://www.cacenter.org/view/newsletter>.

CAC offers consulting services. More information is at http://www.cacenter.org/cac/consultant_services.

MEDICAL ERRORS AND PATIENT SAFETY

Office of the Inspector General Says Hospital Incident Reporting Systems Fall Short

Editorial Note: This item is based on a report issued by the Office of the Inspector General (OIG) of the Department of Health and Human Services in January 2012. (Hospital Incident Reporting Systems Do Not Capture Most Patient Harm, OEI-06-09-00091). The OIG reports that hospital workers report only about 14% of incidents of patient harm. Why should this concern licensing boards and certifying bodies? It is well known that reports from colleagues in healthcare systems more often lead to disciplinary action than

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consumer complaints or reports from other sources.

Many states have mandatory reporting laws that require hospitals and fellow professionals to report to licensing boards instances of patient harm and adverse actions taken by employers against healthcare workers. But many hospitals never file reports of suspensions or other penalties and regulators are not receiving reports of the volume and quality one would expect. This OIG report shows that even hospital

leadership does not know about the vast majority of adverse events in their institutions, so it is not possible for this information to find its way to licensing authorities and other regulators, even if hospitals were dutiful about conforming with reporting requirements. It is noteworthy that this study examines whether incident reports lead first to investigations and subsequently to changes in hospital policy or practices. Hospital authorities interviewed by the OIG were concerned about whether an incident represented a systemic problem within the hospital. The study is not concerned with whether incident reports do or should result in reports to regulatory authorities.

The objectives of the OIG's study were to describe how hospitals use incident reporting systems and incident reports, to determine the extent to which hospital incident reporting systems capture patient harm, and to determine the extent to which accreditors review incident reporting systems as part of their assessments. Hospitals must track and analyze instances of patient harm as a condition of participation in Medicare. OIG research published in 2010 found that 13.5% of Medicare beneficiaries experienced an adverse event during their hospital stay that resulted in prolonged hospitalization or permanent disability, or required life-sustaining intervention. Another 13.5% of beneficiaries experienced adverse events that required treatment, but resulted in only temporary harm. For this report, the OIG returned to the hospitals surveyed in 2010 and interviewed hospital administrators and representatives of accreditors.

These are the OIG's findings:

All sampled hospitals had incident reporting systems to capture events, and administrators we interviewed rely heavily on these systems to identify problems. All 189 hospitals surveyed have systems to capture instances of patient harm. The OIG interviewed risk managers, patient safety officers, and/or quality improvement specialists at 34 hospitals. These individuals (referred to collectively in the report as "administrators") acknowledged that incident-reporting systems fail to reveal how frequently incidents occur, but they still rely on the reporting systems because they value staff accounts of events. Administrators said hospital staff is encouraged to report all instances of patient harm, and is given some instruction as to what that means. None of the hospitals, however, maintains a list of reportable events.

Administrators expressed concern that underreporting can affect patient safety efforts by potentially skewing resources toward prevention of more easily identifiable occurrences

that happen at a point in time (such as patient falls) rather than complex events that occur over a longer period and are more difficult to detect (such as blood clots).

Hospital staff did not report 86% of events to incident reporting systems, partly because of staff misperceptions about what constitutes patient harm. Reporting systems captured only about 14% of adverse events experienced by Medicare beneficiaries discharged in October 2008. Administrators told the OIG that their staffs failed to report events because they did not perceive them to be reportable (62% of all events), or they neglected to report in this particular case, even though they knew the event was reportable (25%).

...hospital staff reported only 2 of the 18 most serious events in our sample (i.e., those events that resulted in permanent disability or death). Serious events not captured by incident reporting systems included hospital-acquired infections, such as a case of septic shock leading to death; and medication-related events, such as four cases of excessive bleeding because of the administration of blood-thinning medication that also led to death. Incident reporting systems did not capture any of the five NQF (National Quality Forum) Serious Reportable Events and only one of the eight Medicare HAC events in our sample. Medicare does not require hospitals to capture information about these events through incident reporting systems. However, because events on the NQF and Medicare HAC lists are widely recognized among medical professionals as constituting patient harm, many among the public and in the health care community may expect them to be reported by hospital staff.

Administrators posited several reasons why staff might consider that an event did not need to be reported:

- Event was not caused by a perceptible error
- Event was an expected outcome or side effect
- Event caused little harm and/or harm was ameliorated
- Event was not on hospital's mandatory reporting list
- Event occurs frequently in hospitals
- Event symptoms became apparent after discharge
- Event occurred in patient with a history of similar events

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Nurses most often reported events, typically identified through the regular course of care; 28 of the 40 reported events led to investigations, and 5 led to policy changes.

Nurses reported 31 of the 40 reported events. Hospitals conducted investigations into 2/3 of the reported events, although there were few changes in hospital policies or practices.

The hospital administrators we interviewed reported that they investigated and analyzed 28 of the 40 events for evidence of system failures or medical errors to inform quality and safety improvement activities... Hospital administrators reported that they did not investigate the remaining 12 events because they suspected that the events were isolated incidents unlikely to recur... The most common type of investigation was a clinical review of a single event, but hospital administrators reported that they regularly analyze events in aggregated event reviews... These clinical reviews were similar to root cause analyses but contained less detail and used fewer resources. The most frequently discussed questions during these clinical reviews included whether staff correctly assessed patients before treatment began; whether the attending physicians; and what contributing factors led to the event, such as a medication mislabeling or poor communication during shift changes, met the standard of care.

Hospitals made few changes to policies or practices as a result of the reported events. Hospital administrators reported that only 4 of the 40 sample incident reports led to a hospital policy or practice change. Two of these events led directly to changes in hospital policy or practice, and staff included the other three in an aggregate event review that led to changes. According to administrators, the remaining 35 reported events did not result in a policy or practice change primarily because hospitals reviewed the event information and determined that the occurrences did not represent systemic quality problems within the hospitals... In other cases, hospital administrators reported that they may already have procedures in place to avoid a specific type of event. For example, hospitals may use special pressure-reducing mattresses and have rigorous policies and training regarding patient turning, yet still see some pressure ulcers develop.

Hospital accreditors reported that in evaluating hospital safety practices, they focus on how event information is used rather than how it is collected. The three accrediting agencies interviewed by the OIG all indicated that they require hospitals to track adverse events as part of safety improvement efforts. Their surveyors do not, however, evaluate the mechanisms hospitals use for event tracking unless they have reason to believe there is a problem with those mechanisms.

Accreditors cited a number of reasons their surveyors do not scrutinize incident reporting systems or other event detection methods during hospital surveys.

Accreditors cited a number of reasons their surveyors do not scrutinize incident reporting systems or other event detection methods during hospital surveys. Most of the reasons rested on the perception that event detection methods are complex and varied. First, hospitals collect event data from a variety of sources, and it can be difficult to discern which information is

from a report and which is from a surveillance record or medical record review.

Second, surveyors may not have the expertise to assess the reporting mechanism itself and provide recommendations to improve reporting. Third, officials questioned the value of requiring hospitals to collect event information in a particular way, arguing that a prescribed approach may inhibit innovation. Given this, some officials reasoned

Editorial Note: State regulatory boards are under criticism for not adequately checking federal databases and / or evidence of disciplinary or malpractice activity in other states. An example is the state of Illinois, which has recently been the subject scrutiny by investigative reporters.

AHRQ Research Finds Hospital Workers Afraid to Report Errors

The Agency for Healthcare Research and Quality (AHRQ) administers a survey periodically to assess the culture of safety in participating hospitals. Survey results released by AHRQ in February 2012 reveal that only an average of 44% of respondents (more than half a million from 1,128 hospitals) feel that “their mistakes and event reports are not held against them and that mistakes are not kept in their personnel file.”

In other words, a majority of physicians, nurses, and other health care professionals working in hospitals continue to perceive a punitive atmosphere in their institutions, which discourages reporting of errors and near misses. This is true despite a trend away from a “shame and blame” approach to medical errors. The lack of reporting, according to some observers, has a detrimental effect on patient safety.

Doctors Admit Lying About Mistakes

A survey national conducted by researchers from Massachusetts General Hospital, led by Harvard Medical School professor, Lisa I. Iezzoni, found that many physicians admit lying or withholding information from patients about medical mistakes and their financial relationships with pharmaceutical and medical devices companies. The research was published in the February 2012 issue of *Health Affairs*. The article’s abstract explains that:

Abstract

Overall, approximately one-third of physicians did not completely agree with disclosing serious medical errors to patients, almost one-fifth did not completely agree that physicians should never tell a patient something untrue, and nearly two-fifths did not completely agree that they should disclose their financial relationships with drug and device companies to patients. Just over one-tenth said they had told patients something untrue in the previous year.

The Charter on Medical Professionalism, endorsed by more than 100 professional groups worldwide and the US Accreditation Council for Graduate Medical Education, requires openness and honesty in physicians’ communication with patients. We present data from a 2009 survey of 1,891 practicing physicians nationwide assessing how widely physicians endorse and follow these principles in communicating with patients. The vast majority of physicians completely agreed that physicians should fully inform patients about the risks and benefits of interventions and should never disclose confidential information to unauthorized persons. Overall, approximately one-third of physicians did not completely agree with disclosing serious medical errors to patients, almost one-fifth did not completely agree that physicians should never tell a patient something untrue, and nearly two-fifths did not completely agree that they should disclose their financial relationships with drug and device companies to patients. Just over one-tenth said they had told patients something untrue in the previous year. Our findings raise concerns that some patients might not receive complete and accurate information from their physicians, and doubts about whether patient-centered care is broadly possible without more widespread physician

that it was better to focus on the output than on the systems, but they conceded that this lack of focus on how hospitals collect event information meant there was little scrutiny of the reporting systems' event data that hospitals use to inform their patient safety improvement efforts.

The report concludes with two recommendations directed at the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS), which are in a position "to provide guidance and incentives for hospitals to more effectively track and analyze adverse events."

The OIG recommends:

AHRQ and CMS should collaborate to create a list of potentially reportable events and provide technical assistance to hospitals in using the list.

Hospital administrators reported that the most common reason hospital staff do not report patient harm is that they do not perceive the harm as a reportable event. As such, hospital efforts to improve patient safety may be limited by focusing on only a small subset of events that get more attention because they are more often reported by staff... (T)he list of events would educate hospital staff about the full range of patient harm that occurs in hospitals and should be reported to incident reporting systems. The list should go beyond the fairly rare harm events included in the NQF and Medicare HAC lists and include a comprehensive range of possible patient harm.

CMS should provide guidance to accreditors for assessment of hospital efforts to track and analyze events and should scrutinize survey processes when approving accreditation programs.

CMS is testing draft interpretive guidelines for surveyors ... including guidance about how surveyors are to assess hospital operations for tracking patient harm... (W)e recommend that this guidance include information about how surveyors should assess hospital event collection efforts, including incident reporting systems, and should include the list of potentially reportable events... CMS should also suggest that surveyors evaluate the information collected by hospitals and compare it to the data elements of AHRQ's Common Format event reporting tools... Additionally, CMS should scrutinize survey standards for assessing hospital compliance with the requirement to track and analyze events and reinforce assessment of incident reporting systems as a key tool to improve event identification and tracking. *Given the low reporting rates and lack of assessment by accreditors during hospital surveys, CMS should ensure that accreditation survey practices bring about a meaningful examination of systems that identify events, including mechanisms for reporting events, and hospital efforts to address underreporting and use information.* (Emphasis added.)

Given the low reporting rates and lack of assessment by accreditors during hospital surveys, CMS should ensure that accreditation survey practices bring about a meaningful examination of systems that identify events, including mechanisms for reporting events, and hospital efforts to address underreporting and use information.

endorsement of the core communication principles of openness and honesty with patients.

The complete article is at <http://content.healthaffairs.org/content/31/2/383.abstract>.

New Databases Document Adverse Events for Consumers

Two startup companies, “AdverseEvents” and “Clarimed” are developing online databases containing data on adverse events associated with 4,500 prescription drugs and 130,000 medical devices. These will supplement the Food and Drug Administration’s Adverse-event Reporting System (AERS) and Manufacturer and User Facility Device Experience (Maude).

The AdverseEvents database filters duplicate reports in AERS and combines spelling inconsistencies. It enables consumers to search for and compare thousands of conditions and prescription drug side effects from 2004. Access to more comprehensive searches will cost \$10 per month. Clarimed also plans to charge for access to its database about medical device adverse events.

Consumer Reports Adds Voice to Hospital Safety Ratings

In the summer of 2012, Consumer Reports issued new hospital safety ratings. These ratings supplement, complement hospital safety ratings issued by some states, the Centers for Medicare and Medicaid Services, the Leapfrog Group, and popular magazines, such as *US News and World Reports*. Because various organizations judge hospital safety according to different variables, their ratings are not always consistent. For example, see <http://ideas.time.com/2012/07/11/why-the-best-hospitals-might-also-be-the-most-dangerous/#ixzz20RLequh6>.

With characteristic comprehensiveness, Consumer Reports explains its ratings at <http://www.consumerreports.org/cro/magazine/2012/08/how-safe-is-your-hospital/index.htm?loginMethod=auto>.

Editorial Note: More information is generally desirable, but when ratings like these are inconsistent or contradictory, there is great potential for consumer confusion or mistrust about ratings. We hope that various rating systems can be made more consistent. At a minimum, the various rating entities should explain the basis for their ratings and the reasons for discrepancies with other rating systems.

SCOPE OF PRACTICE

Expanded Scope for Nurse Practitioners Does Not Affect M.D. Pay

Researchers at George Washington University School of Public Health and Health Services analyzed Bureau of Labor Statistics data and concluded that expanding the scope of practice of nurse practitioners does not affect primary care physician pay levels.

Lead researcher Patricia Pittman, PhD said that this study is a first step in the “important (task of) systematically assess(ing) whether there are negative consequences for primary care doctors associated with an expanded role for nurse practitioners.”

The research was published in the 2012 edition of *Nursing Research and Practice*. See <http://bit.ly/wqS6gU>.

Wisconsin: Entities Required to Report Possible Violations, and Penalties for Failure to Report.

See generally, §§ 448.02(3)(a), 448.675(1)(a), Wis. Stats.¹

Entity		Statutory Support
Licensees		<p>Licensees "may" report. See Wis. Stat. § 50.09(6)(b) (emphasis added): (Ch. 50 Uniform Licensure)</p> <p>(6)(b) Allegations of violations of such rights by persons licensed, certified or registered under chs. 441, 446 to 450, 455 and 456 shall be promptly reported by the facility to the appropriate licensing, examining or affiliated credentialing board and to the person against whom the allegation has been made. Any employee of the facility and any person licensed, certified or registered under chs. 441, 446 to 450, 455 and 456 may also report such allegations to the board. Such board may make further investigation and take such disciplinary action, within the board's statutory authority, as the case requires.</p>
Licensee Committing a Violation		<p>* According to the chart, NY and WI are the only states that do not require reporting from either Licensees or Licensees Committing a Violation. The majority of states require both to report.</p>
Courts	X	<p>See Wis. Stat. § 655.45 Reports to licensing bodies: (Ch. 655 Health Care Liability and Injured Patients & Families Compensation)</p> <p>(1) For the quarter beginning on July 1, 1986, and for each quarter thereafter, the director of state courts shall file reports complying with sub. (2) with the medical examining board, the physical therapists affiliated credentialing board, the podiatrists affiliated credentialing board, the board of nursing and the department, respectively, regarding health care providers licensed by the respective bodies.</p> <p>(1m) For the quarter beginning on July 1, 1995, and for each quarter thereafter, the director of state courts shall file reports complying with sub. (2) with the dietitians affiliated credentialing board regarding health care providers certified by the dietitians affiliated credentialing board.</p> <p>(2) The reports under subs. (1) and (1m) shall set forth all of the following:</p> <p>(a) The names of all health care providers who are named as defendants in court actions of which the director of state courts receives notice under s. 655.44 (6) or 655.445 (1) during the quarter.</p> <p>(b) Whether any court action of which the director of state courts received notice under s. 655.44 (6) or 655.445 (1) was disposed of by settlement, compromise, stipulation agreement, dismissal default or judgment during the quarter and the amount of the settlement or award to the claimant, if any, to the extent the director of state courts has any of the information under this paragraph.</p>

¹ All references to the Wisconsin States are to the 2005-06 version (updated through May 31, 2007 and 2007 Wis. Act 14) unless otherwise noted.

Entity		Statutory Support
Hospitals (Staff and Administrators)	X	<p data-bbox="625 396 1879 418"><i>See Wis. Stat. § 50.09 Rights of residents in certain facilities:</i> (Ch. 50 Uniform Licensure)</p> <p data-bbox="701 444 1745 516">(6)(a) Each facility shall establish a system of reviewing complaints and allegations of violations of residents' rights established under this section. The facility shall designate a specific individual who, for the purposes of effectuating this section, shall report to the administrator.</p> <p data-bbox="701 537 1745 651">(6)(b) Allegations of violations of such rights by persons licensed, certified or registered under <u>chs. 441, 446 to 450, 455 and 456</u> shall be promptly reported by the facility to the appropriate licensing, examining or affiliated credentialing board and to the person against whom the allegation has been made. Any employee of the facility and any person licensed, certified or registered under <u>chs. 441, 446 to 450, 455 and 456</u> may also report such allegations to the board. Such board may make further investigation and take such disciplinary action, within the board's statutory authority, as the case requires.</p> <p data-bbox="701 672 1717 716">(6)(c) No person who files a report as required in <u>par. (b)</u> or who participates, in good faith, in the review system established under <u>par. (a)</u> shall be liable for civil damages for such acts.</p> <p data-bbox="701 737 1745 829">(6)(d) The facility shall attach a statement, which summarizes complaints or allegations of violations of rights established under this section, to the report required under <u>s. 50.03 (4) (c) 1. or 2.</u> The statement shall contain the date of the complaint or allegation, the name of the persons involved, the disposition of the matter and the date of disposition. The department shall consider the statement in reviewing the report.</p> <p data-bbox="625 850 1879 878"><i>See Wis. Stat. § 146.40 Instructional programs for nurse's aides; reporting client abuse:</i> (Ch. 146 Miscellaneous Health Provisions)</p> <p data-bbox="701 899 1717 992">146.40(4r)(am)2 An entity shall report to the department of regulation and licensing any allegation of misappropriation of the property of a client or of neglect or abuse of a client by any person employed by or under contract with the entity if that person holds a credential that is related to the person's employment at, or contract with, the entity if the person is under the control of the entity.</p> <p data-bbox="701 1013 1545 1040">... 146.40 (7) This section does not apply to a hospice that receives no federal or state moneys for any purpose.</p> <p data-bbox="701 1105 1717 1198">50.065(1)(c) "Entity" means a facility, organization or service that is licensed or certified by or registered with the department to provide direct care or treatment services to clients. "Entity" includes a hospital, a personal care worker agency, a supportive home care service agency, a temporary employment agency that provides caregivers to another entity and the board on aging and long-term care. "Entity" does not include any of the following: ...</p>

Entity		Statutory Support
Managed Care Organizations	X	<p><i>See Wis. Stat. § 609.17 Reports of disciplinary action:</i> (Ch. 609 Defined Network Plans)</p> <p>Every limited service health organization, preferred provider plan, and defined network plan shall notify the medical examining board or appropriate affiliated credentialing board attached to the medical examining board of any disciplinary action taken against a participating provider who holds a license or certificate granted by the board or affiliated credentialing board.</p>
Liability Insurance Carrier(s)	X	<p><i>See Wis. Stat. § 632.715 Reports of action against health care provider:</i> (Ch. 632 Insurance Contracts in Specific Lines)</p> <p>Every insurer that has taken any action against a person who holds a license granted by the medical examining board or an affiliated credentialing board attached to the medical examining board shall notify the board or affiliated credentialing board of the action taken against the person if the action relates to unprofessional conduct or negligence in treatment by the person who holds the license.</p>
Local Medical/Osteopathic Societies	X	?
Local Professional Societies		
Other State Agencies	X	<p>DEPARTMENT OF HEALTH AND FAMILY SERVICES. <i>See Wis. Stat. § 49.45 Medical assistance; administration:</i> (Ch. 49 Public Assistance, Subch. IV Medical Assistance)</p> <p>(2) Duties ... (a) The department shall: ... 12r. Notify the medical examining board, or any affiliated credentialing board attached to the medical examining board, of any decertification or suspension of a person holding a license granted by the board or the affiliated credentialing board if the grounds for the decertification or suspension include fraud or a quality of care issue.</p> <p>DEPARTMENT OF HEALTH AND FAMILY SERVICES. <i>See Wis. Stat. § 146.40 Instructional programs for nurse's aides; reporting client abuse:</i> (Ch. 146 Miscellaneous Health Provisions)</p> <p>... 146.40(4r)(em) If the department of health and family services receives a report under <u>par. (a)</u> or <u>(am)</u> and determines that a person who is the subject of the report holds a credential that is related to the person's employment at, or contract with, the entity, the department of health and family services shall refer the report to the department of regulation and licensing.</p>

Entity		Statutory Support
State/Local Law Enforcement Agencies		
State Medical/Osteopathic Societies		
State Professional/Specialty Societies		
Professional/Peer Review Organizations		
Physicians Treating Physicians for Special Disorders		
Other Health Care Professions		Pharmacy?
Federal Agencies	X	<p style="text-align: right;">Title 42 Public Health General – Health Care, Department of Health and Human Services Part 1001 Program Integrity Medicare and State Health Care Programs Subpart E Notice and Appeals</p> <p><i>See</i> 42 CFR 1001.2005 (2006) Notice to State licensing agencies:</p> <p>(a) HHS will promptly notify the appropriate State(s) or local agencies or authorities having responsibility for the licensing or certification of an individual or entity excluded (or directed to be excluded) from participation of the facts and circumstances of the exclusion.</p> <p>(b) HHS will request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and will request that the State or local agency or authority keep the Secretary and the OIG fully and currently informed with respect to any actions taken in response to the request.</p> <p><i>See also</i>, §§ 448.02(3)(a), 448.675(1)(a), Wis. Stats. (board shall investigate info contained in reports filed under 42 CFR 1001.2005)</p>
Civil Penalty for Failure to Report? Yes/No		<p>Depends on good faith reporting. <i>See</i> Wis. Stat. 655.26(4):</p> <p>(4) Any person who in good faith provides information to the medical examining board or the board of governors under this section is immune from civil liability for his or her acts or omissions in providing such information.</p>

Wisconsin: What Hospitals and Liability Carriers Must Report.

		Report	Statutory Support
Hospitals	Privilege Revocation	X	<p><i>See Wis. Stat. § 50.36 Rules and standards:</i> (Ch. 50 Uniform Licensure, Subch. II Hospitals)</p> <p>(3)(a) Any person licensed to practice medicine and surgery under <u>subch. II</u> of ch. 448 or podiatry under <u>subch. IV</u> of ch. 448 shall be afforded an equal opportunity to obtain hospital staff privileges and may not be denied hospital staff privileges solely for the reason that the person is an osteopathic physician and surgeon or a podiatrist. Each individual hospital shall retain the right to determine whether the applicant's training, experience and demonstrated competence is sufficient to justify the granting of hospital staff privileges or is sufficient to justify the granting of limited hospital staff privileges.</p> <p>(3)(b) If, as a result of peer investigation or written notice thereof, a hospital staff member who is licensed by the medical examining board or podiatrists affiliated credentialing board, for any reasons that include the quality of or ability to practice, loses his or her hospital staff privileges, has his or her hospital staff privileges reduced or resigns from the hospital staff, the hospital shall so notify the medical examining board or podiatrists affiliated credentialing board, whichever is applicable, within 30 days after the loss, reduction or resignation takes effect. Temporary suspension due to incomplete records need not be reported.</p> <p>(3)(c) If, as a result of peer investigation or written notice thereof, a hospital staff member who is licensed by the medical examining board or podiatrists affiliated credentialing board, for reasons that do not include the quality of or ability to practice, loses his or her hospital staff privileges for 30 days or more, has his or her hospital staff privileges reduced for 30 days or more or resigns from the hospital staff for 30 days or more, the hospital shall so notify the medical examining board or podiatrists affiliated credentialing board, whichever is applicable, within 30 days after the loss, reduction or resignation takes effect. Temporary suspension due to incomplete records need not be reported.</p> <p><i>See also, Wis. Stat. § 488.02(7) Hospital Reports</i> (Medical Examining Board procedures following receipt of Hospital Report).</p>
	Privilege Suspension	X	<i>See id.</i>
	Privilege Restriction	X	<i>See id.</i>
	Voluntary Surrender of Privileges	X	? <i>See also, id.</i> (may include voluntary surrender)
	Voluntary Restriction of Privileges	X	? <i>See also, id.</i> (may include voluntary restriction)

Liability Carriers	All Claims	X	? Wis. Stat. § 655.26 (below) seems to apply only to "claim[s] paid during the previous month for damages..." and not <i>all</i> claims.
	All Liability Payments Made By Carrier	X	<p>See Wis. Stat. § 655.26 Reports on claims paid: (Ch. 655 Health Care Liability & Insured Patients & Families Compensation, Subch. III Ins. Prov'ns.)</p> <p>(1) In addition to any information required by the commissioner under s. 601.42, by the 15th day of each month, each insurer that writes health care liability insurance in this state and each self-insurer approved under s. 655.23 (3) (a) shall report the following information to the medical examining board and the board of governors on each claim paid during the previous month for damages arising out of the rendering of health care services:</p> <ul style="list-style-type: none"> (a) The name and address of the policyholder or self-insured entity and the name and address of any individual on whose behalf the claim was paid. (b) The profession of the individual or the type of facility or entity on whose behalf the claim was paid. (c) The health care provider's medical specialty, if the provider is a physician. (d) A description of the injury, including its cause and severity. (e) Whether the claim was paid as a result of a settlement, a patients compensation panel award or a court award. (f) The amount of the payment. (g) The number and amounts of any previous claims paid by the insurer or self-insurer for damages arising out of the rendering of health care services by the insured, the self-insurer or the employees of the insured or self-insurer. Only claims paid on or after July 20, 1985, are required to be reported under this paragraph. (h) Any additional information requested by the medical examining board or the board of governors. <p>(2) By the 15th day of each month, the board of governors shall report the information specified in sub. (1) to the medical examining board for each claim paid by the fund during the previous month for damages arising out of the rendering of health care services by a health care provider or an employee of a health care provider.</p> <p>(3) If more than one payment will be made on a claim, the first report filed under sub. (1) or (2) after the first payment is made on the claim shall include the total amount of the award or settlement and the projected schedule and amounts of payments.</p> <p>(4) Any person who in good faith provides information to the medical examining board or the board of governors under this section is immune from civil liability for his or her acts or omissions in providing such information.</p> <p>See Wis. Admin. Code. Ins. 17.275 Claims information; confidentiality.</p> <p>(4) DISCLOSURE. Confidential claims information may be disclosed only as follows:</p> <ul style="list-style-type: none"> (a) To the medical examining board as provided under s. 655.26, Stats.
	Dollar Amount Above Which All Payments Must Be Reported	\$0	Dollar amount does not affect reporting requirement. See above, Wis. Stat. § 655.26(1) ("each insurer... shall report... on each claim paid...").
	Self-Insureds Must Also Report	X	See above, Wis. Stat. § 655.26. (section applies to self-insurer as approved under s. 655.23 (3) (a).)

State of Wisconsin



2009 Assembly Bill 877

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

2009 WISCONSIN ACT 382

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

III. SOURCES OF INFORMATION

A. Designated as “informal complaints” [Wis. Adm. Code § RL 2.03 (7)]

1. Hospital Reports under Wis. Stat. § 50.36(3)(b) and (c):
 - a. Hospitals must report to the MEB any physician having a loss, resignation or reduction of staff privileges resulting from peer investigation for a reason which relates to quality of practice or ability to practice.
 - b. Hospitals must report to the MEB any physician having a loss, resignation or reduction of staff privilege lasting at least 30 days, resulting from peer investigation for a reason which does not relate to quality practice or ability to practice. [Wis. Stat. § 50.36(3)(c)]
2. Health Maintenance Organizations, limited service health organizations and preferred provider plans shall notify MEB of any disciplinary action taken against any participating physician. [Wis. Stat. § 609.17]
3. Director of state courts shall file quarterly reports with the MEB of:
 - a. The names of all physicians named as defendants in court actions of which the director receives notice by requests for mediation under s. 655.44 (6) or 655.445 (1) during the quarter. [Wis. Stat. § 655.45(2)(a)]
 - b. Whether any of those actions was disposed of by settlement, compromise, stipulation agreement, dismissal default or judgment during the quarter and the amount of the settlement or award to the claimant, if any, to the extent the director has that information. [Wis. Stat. § 655.45(2)(b)]
4. Reports of claims paid:
 - a. Any insurer that writes health care liability insurance in this state and each self-insurer shall report to the MEB on each claim paid during the previous month for damages arising out of the rendering of health care services. The information includes the name, profession and specialty of any individual on whose behalf the claim was made. [Wis. Stat. §655.26]
 - b. The board of governors of the patients’ compensation fund shall report to the MEB the same information for each claim paid by the fund during the previous month for damages arising out of the rendering of health care services by a health care provider or an employee of a health care provider. [Wis. Stat. §655.26]
5. The Health Care Quality Improvement Act of 1986, 42 U.S.C. sec. 11101 et. seq. requires:
 - a. Report of payments in malpractice action or claim shall be made to the MEB where the claim arose. [USC 11131 and 11134(c)(1)]

- b. Report by any health care entity to the MEB any time a health care entity takes a professional review (peer review) action that adversely affects the clinical privileges of a physician for a period longer than 30 days or accepts the surrender of clinical privileges of a physician while the physician is under an investigation relating to possible incompetence or improper professional conduct, or in return for not conducting such an investigation or proceeding. [42 USC 11133(a)(1)]
 - c. National Practitioners Data Bank reports to the MEB claims paid and actions which take place in other states relating to physicians licensed here.
6. Utilization and quality control peer review organization and DR&L report to each other information including names of physicians subject to adverse determinations made during the Medicare physician review and sanction process. [42 U.S.C. sec. 1320c-9 (b)]
 7. Federation of State Medical Examining Boards is an organization made up of most state medical licensing entities. It functions as a clearing house on disciplines and notifies MEB of actions taken by other states.
 8. Department of Health and Family Services shall notify the MEB of any decertification or suspension of a physician from the medical assistance program if the grounds for the decertification or suspension include fraud or a quality of care issue. [Wis. Stat. § 49.45.]
 9. Department of Justice or the district attorney shall notify MEB of any prosecution of a physician for violation of criminal laws affecting the medical assistance program. [Wis. Stat. § 49.495.]
 10. Psychotherapist who has reason to believe a client has been sexually exploited by a physician-psychotherapist shall report to MEB if client consents to the report. [Wis. Stat. § 940.22(3).]
 11. Other sources:
 - a. Patients.
 - b. Family and friends of patients.
 - c. Other physicians.
 - i. Physicians are provided immunity from liability for damages that may result from providing information to MEB, in good faith which is presumed, concerning an allegation that another physician has engaged in unprofessional conduct or acted negligently in treatment. [Wis. Stat. § 448.03(5)(c)]
 - ii. The MEB may not discipline the physician for providing the information. [Wis. Stat. § 448.03(5)(c)]
 - d. Other credential holders (pharmacists, psychologists, nurses, chiropractors, etc).
 - e. Police and district attorneys.
 - f. Media.
- B. Anyone making a report in good faith (which is presumed to exist) is immune from civil liability. [Wis. Stat. § 440.042 (2)]

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