



MEDICAL EXAMINING BOARD
Room 121A, 1400 East Washington Avenue, Madison
Contact: Tom Ryan (608) 266-2112
August 20, 2014

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

AGENDA

8:00 A.M.

OPEN SESSION – CALL TO ORDER – ROLL CALL

- A) Adoption of Agenda (1-5)**
- B) Approval of Minutes of July 16, 2014 (6-11)**
- C) Administrative Updates**
 - 1) Staff Updates
- D) Presentation of the Petition for Rehearing – Dr. Zulfiqar Ali**
 - 1) **8:00 A.M. – APPEARANCE** – Dr. Zulfiqar Ali
 - 2) **8:00 A.M. – APPEARANCE** – DLSC Attorney Sandra Nowack
- E) Newsletter Matters**
- F) Federation of State Medical Boards (FSMB) Matters – Discussion and Consideration**
 - 1) State Medical Boards Launch Educational Effort to Equip Physicians for Safe Prescribing of Opioid Analgesics **(12-14)**
- G) Legislative/Administrative Rule Matters**
 - 1) **8:30 A.M. – PUBLIC HEARING** – Clearinghouse Rule 14-040 Relating to Physicians and Informed Consent **(15-24)**
 - 2) Current and Future Rule Making and Legislative Initiatives
 - 3) Administrative Rules Report
 - 4) Review of Preliminary Rule Draft of Pod 4 Biennial Registration **(25-28)**
 - 5) 2013 Wisconsin Act 114 and Wis. Admin Code Med 1 **(29-31)**
- H) Legal Representative Present During Two Person Oral Examination – Discussion and Consideration (32-34)**
- I) Speaking Engagement(s), Travel, or Public Relation Request(s)**

- J) Licensing Committee Report
- K) Disciplinary Guidelines Committee Report
- L) Screening Panel Report
- M) Correspondence Regarding Heterogeneity in Physician Diagnosis and Treatment (35-43)**
- N) Informational Items**
 - 1) Maintenance of Certification Took Center Stage at AMA Congress of Delegates **(44-46)**
 - 2) Changes to USMLE 2014-2015 **(47-49)**
- O) Items Added After Preparation of Agenda:
 - 1) Introductions, Announcements and Recognition
 - 2) Administrative Updates
 - 3) Education and Examination Matters
 - 4) Credentialing Matters
 - 5) Practice Matters
 - 6) Legislation/Administrative Rule Matters
 - 7) Liaison Report(s)
 - 8) Informational Item(s)
 - 9) Disciplinary Matters
 - 10) Presentations of Petition(s) for Summary Suspension
 - 11) Presentation of Proposed Stipulation(s), Final Decision(s) and Order(s)
 - 12) Presentation of Proposed Decisions
 - 13) Presentation of Interim Order(s)
 - 14) Petitions for Re-Hearing
 - 15) Petitions for Assessments
 - 16) Petitions to Vacate Order(s)
 - 17) Petitions for Designation of Hearing Examiner
 - 18) Requests for Disciplinary Proceeding Presentations
 - 19) Motions
 - 20) Petitions
 - 21) Appearances from Requests Received or Renewed
 - 22) Speaking Engagement(s), Travel, or Public Relation Request(s)
- P) Public Comments

CONVENE TO CLOSED SESSION to deliberate on cases following hearing (§ 19.85 (1) (a), Stats.); to consider licensure or certification of individuals (§ 19.85 (1) (b), Stats.); to consider closing disciplinary investigations with administrative warnings (§ 19.85 (1) (b), Stats. and § 448.02 (8), Stats.); to consider individual histories or disciplinary data (§ 19.85 (1) (f), Stats.); and to confer with legal counsel (§ 19.85 (1) (g), Stats.).

- Q) Full Board Oral Examination of Candidates for Licensure:**
 - 1) **9:45 A.M. – APPEARANCE – Justin Ribault, M.D. (50-106)**
- R) Deliberation of the Petition for Rehearing – Dr. Zulfiqar Ali (107-143)**

- S) Monitoring Matters**
- 1) Steven L. Armus, M.D. – Requesting Full Unlimited Licensure **(144-171)**
 - 2) Thomas A. O’Connor, M.D. – Requesting Full Unlimited Licensure **(172-185)**
- T) Presentation and Deliberation on Proposed Stipulations, Final Decisions and Orders by the Division of Legal Services and Compliance (DLSC)**
- 1) Jeffrey J. Entress, M.D. – 13 MED 199 **(186-192)**
 - a) Case Advisor: Russell Yale, M.D.
 - 2) Vibha Agrawal, M.D. – 13 MED 225 **(193-200)**
 - a) Case Advisor: Sridhar Vasudevan, M.D.
 - 3) James J. Logan, M.D. – 13 MED 260 **(201-210)**
 - a) Case Advisor: Sridhar Vasudevan, M.D.
 - 4) John W.P. Horan, M.D. – 13 MED 262 **(211-216)**
 - a) Case Advisor: Mary Jo Capodice, M.D.
 - 5) Donald M. Jacobson, M.D. – 13MED275 **(217-225)**
 - a) Case Advisor: Sridhar Vasudevan, M.D.
 - 6) Kevin C. Nepsund, M.D. – 14 MED 028 **(226-232)**
 - a) Case Advisor: Sridhar Vasudevan, M.D.
 - 7) Francis E. Harrington, M.D. – 14 MED 055 **(233-239)**
 - a) Case Advisor: Jude Genereaux
 - 8) James O. Steele, M.D. – 14 MED 066 **(240-246)**
 - a) Case Advisor: Sridhar Vasudevan, M.D.
 - 9) Richard N. Barney, M.D. – 14 MED 153 **(247-252)**
 - a) Case Advisor: Carolyn Ogland Vukich, M.D.
- U) Presentation and Deliberation on Complaints for Determination of Probable Cause**
- 1) Steven G. Meress, M.D. – 11 MED 363 **(253-263)**
- V) Presentation and Deliberation on Administrative Warnings**
- 1) 13 MED 008 (B.N.) **(264-265)**
 - 2) 13 MED 323 (D.L.Z.) **(266-270)**
 - 3) 13 MED 323 (R.J.T.) **(271-273)**
 - 4) 13 MED 448 (R.N.) **(274-275)**
 - 5) 13 MED 453 (B.C.) **(276-280)**
 - 6) 13 MED 453 (J.H.) **(281-285)**
 - 7) 13 MED 529 (A.M.D.) **(286-287)**
 - 8) 14 MED 160 (K.F.K.) **(288-289)**
- W) Seeking Equivalency for the 12 Months of ACGME Approved Post-Graduate Training Based on Education and Training**
- 1) Nitinrai Pandya, M.D. **(290-413)**
- X) Case Status Report (414-424)**

Y) Case Closing(s)

- 1) 13 MED 089 (M.B.B. and H.K.) **(425-440)**
- 2) 13 MED 269 (D.H., R.M., D.P., Q.Q., and A.S.) **(441-456)**
- 3) 13 MED 453 (P.S.) **(457-461)**
- 4) 13 MED 454 (L.P.S.) **(462-464)**
- 5) 13 MED 484 (T.A.Z. and K.M.S.) **(465-475)**
- 6) 13 MED 495 (C.L.) **(476-487)**
- 7) 14 MED 067 (K.A.W.) **(488-491)**
- 8) 14 MED 223 (G.D.M.) **(492-494)**

Z) Deliberation of Items Added After Preparation of the Agenda

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

AA) Consulting with Legal Counsel

RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION

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

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

DD) Delegation of Ratification of Examination Results and Ratification of Licenses and Certificates

ADJOURNMENT

**ORAL EXAMINATION OF CANDIDATES FOR LICENSURE
ROOM 121A, 121B, AND 124E
12:00 P.M., OR IMMEDIATELY FOLLOWING FULL BOARD MEETING**

CLOSED SESSION – Reviewing applications and conducting oral examinations of five (5) candidates for licensure – Drs. Capodice, Erickson, Phillips, and Yale

**MEDICAL EXAMINING BOARD
MEETING MINUTES
July 16, 2014**

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

EXCUSED: James Barr; Timothy Westlake, M.D.

STAFF: Tom Ryan, Executive Director; Pam Stach, Legal Counsel; Kimberly Wood, Program Assistant Supervisor; and other Department staff

CALL TO ORDER

Kenneth Simons, Chair, called the meeting to order at 8:01 A.M. A quorum of eleven (11) members was confirmed.

ADOPTION OF AGENDA

Amendments:

- **After Item T.4 (Closed Session):** Under the agenda item titled “ Presentation and Deliberation on Proposed Stipulations, Final Decisions and Orders by the Division of Legal Services and Compliance (DLSC)” **ADD:**
 - Item T.5: Ronald G. Rubin, M.D., Case Number 13 MED 039
- **Item H.3 (Open Session):** Under the agenda item titled “Legislative/Administrative Rule Matters - Review and Discussion of Requirements for Documenting and Retaining Records of Physician Assistants’ Supervising Physician” **REMOVE:**
 - Item H.3.A: Appearance by Joost Kap

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

APPROVAL OF MINUTES

MOTION: Suresh Misra moved, seconded by Michael Phillips, to approve the minutes of June 18, 2014 as published. Motion carried unanimously.

**BOARD CONSIDERATION OF A MOTION IN
APPRECIATION OF JUDE GENEREAUX’S SERVICE**

MOTION: Timothy Swan moved, seconded by Carolyn Ogland, to recognize Jude Genereaux for her many years of service to the Medical Examining Board and for all her efforts to protect public health and safety. Motion carried unanimously.

**REPORT ON THE NATIONAL PRACTITIONER DATA BANK
CONTINUOUS QUERY PROGRAM**

MOTION: Rodney Erickson moved, seconded by Greg Collins, to rescind the April motion regarding a Department study of the Continuous Query option of the NPDB, and to continue to monitor databank services. Motion carried unanimously.

LEGISLATIVE/ADMINISTRATIVE RULE MATTERS

Review and Discussion of Requirements for Documenting and Retaining Records of Physician Assistants' Supervising Physician

MOTION: Rodney Erickson moved, seconded by Carolyn Ogland, to approve form # 2594 as amended. Motion carried unanimously.

SPEAKING ENGAGEMENT(S), TRAVEL, OR PUBLIC RELATION REQUEST(S)

MOTION: Sridhar Vasudevan moved, seconded by Mary Jo Capodice, to authorize Kenneth Simons to attend and participate in discussion at the Alliance of Health Insurers Annual Meeting on September 9, 2014. Motion carried unanimously.

Citizen Advocacy Center (CAC) 2014 Annual Meeting, October 23-24, 2014, in Baltimore, Maryland

MOTION: Sridhar Vasudevan moved, seconded by Mary Jo Capodice, to designate Robert Zondag or Greg Collins to attend the Citizen Advocacy Center (CAC) 2014 Annual Meeting on October 23-24, 2014 in Baltimore, Maryland and to authorize travel. Motion carried unanimously.

CLOSED SESSION

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

The Board convened into Closed Session at 9:13 A.M.

RECONVENE TO OPEN SESSION

MOTION: Sridhar Vasudevan moved, seconded by Robert Zondag, to reconvene in Open Session at 10:35 A.M. Motion carried unanimously.

FULL BOARD ORAL EXAMINATION OF CANDIDATES FOR LICENSURE

MOTION: Greg Collins moved, seconded by Robert Zondag, to find that Christian Maduoma, M.D., failed the MEB Full Board Oral Examination. **Reason for Denial:** Based upon the information of record and applicant's oral examination, applicant is not currently competent to practice with reasonable skill and safety. Motion carried.

MOTION: Suresh Misra moved, seconded by Russell Yale, to deny the application of Christian Maduoma, M.D., for a license to practice Medicine and Surgery in the State of Wisconsin. **Reason for Denial:** Failure of the MEB Full Board Oral Examination. Motion carried.

MONITORING MATTERS

James P. Fogarty, M.D. – Requesting Return to Full Licensure

MOTION: Sridhar Vasudevan moved, seconded by Michael Phillips, to grant the request of James P. Fogarty, M.D. for return of full licensure. Motion carried unanimously.

Devinder K. Sidhu, M.D. – Requesting to Practice Anesthesiology

MOTION: Sridhar Vasudevan moved, seconded by Mary Jo Capodice, to grant the request of Devinder K. Sidhu, M.D. for removal of Anesthesiology practice restrictions, elimination of the requirement for AA/NA attendance, and reduction in the frequency of therapy visits. Motion carried unanimously.

**PRESENTATION AND DELIBERATION ON PROPOSED STIPULATIONS, FINAL
DECISIONS AND ORDERS BY THE DIVISION OF LEGAL SERVICES AND COMPLIANCE
(DLSC)**

Jeffrey B. Gorelick, M.D. – 11 MED 360, 11 MED 361, and 13 MED 083

MOTION: Suresh Misra moved, seconded by Carolyn Ogland, to accept the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Jeffrey B. Gorelick, M.D., DLSC case numbers 11 MED 360, 11 MED 361, and 13 MED 083. Motion carried.

(Sridhar Vasudevan recused himself and left the room for deliberation and voting in the matter concerning Jeffrey B. Gorelick, M.D., Respondent – DLSC case numbers 11 MED 360, 11 MED 361, and 13 MED 083.)

David A. Van De Loo, M.D. – 12 MED 316 and 13 MED 151

MOTION: Greg Collins moved, seconded by Suresh Misra, to accept the Findings of Fact, Conclusions of Law, and Order in the matter of disciplinary proceedings against David A. Van De Loo, M.D., DLSC case numbers 12 MED 316 and 13 MED 151. Motion carried unanimously.

Graig A. Aders, M.D. – 12 MED 381

MOTION: Sridhar Vasudevan moved, seconded by Russell Yale, to accept the Findings of Fact, Conclusions of Law, and Order in the matter of disciplinary proceedings against Graig A. Aders, M.D., DLSC case number 12 MED 381. Motion carried.

(Kenneth Simons recused himself and left the room for deliberation and voting in the matter concerning Graig A. Aders, M.D., Respondent – DLSC case number 12 MED 381.)

Robert J. Smith, M.D. – 13 MED 227

MOTION: Greg Collins moved, seconded by Suresh Misra, to accept the Findings of Fact, Conclusions of Law, and Order in the matter of disciplinary proceedings against Robert J. Smith, M.D., DLSC case number 13 MED 227. Motion carried unanimously.

Ronald G. Rubin, M.D. – 13 MED 039

MOTION: Greg Collins moved, seconded by Suresh Misra, to accept the Findings of Fact, Conclusions of Law, and Order in the matter of disciplinary proceedings against Ronald G. Rubin, M.D., DLSC case number 13 MED 039. Motion carried unanimously.

**PRESENTATION AND DELIBERATION ON COMPLAINTS FOR
DETERMINATION OF PROBABLE CAUSE**

Jeffrey J. Entress, M.D. – 13 MED 199

MOTION: Carolyn Ogland moved, seconded by Suresh Misra, to find probable cause to believe that Jeffrey J. Entress, M.D., DLSC case number 13 MED 199, is guilty of unprofessional conduct, and therefore to issue the Complaint and hold a hearing on such conduct pursuant to Wis. Stat. § 448.02(3)(b). Motion carried.

(Michael Phillips recused himself and left the room for deliberation and voting in the matter concerning Jeffrey J. Entress, M.D., Respondent – DLSC case number 13 MED 199.)

Mary Burgesser-Howard, M.D. – 13 MED 501

MOTION: Mary Jo Capodice moved, seconded by Robert Zondag, to find probable cause to believe that Mary Burgesser- Howard, M.D., DLSC case number 13 MED 501, is guilty of unprofessional conduct, and therefore to issue the Complaint and hold a hearing on such conduct pursuant to Wis. Stat. § 448.02(3)(b). Motion carried unanimously.

PRESENTATION AND DELIBERATION ON ADMINISTRATIVE WARNINGS

13 MED 125 (B.E.R.)

MOTION: Sridhar Vasudevan moved, seconded by Michael Phillips, to issue an Administrative Warning in the matter of DLSC case number 13 MED 125 (B.E.R.). Motion carried unanimously.

13 MED 226 (K.J.B.)

MOTION: Timothy Swan moved, seconded by Sridhar Vasudevan, to issue an Administrative Warning in the matter of DLSC case number 13 MED 226 (K.J.B.). Motion carried. Abstentions: 2, Recusals: 1

(Russell Yale recused himself and left the room for deliberation and voting in the matter DLSC case number 13 MED 226 (K.J.B.))

CASE CLOSING(S)

13 MED 331 (V.S.)

MOTION: Mary Jo Capodice moved, seconded by Suresh Misra, to close the following cases according to the recommendations by the Division of Legal Services and Compliance:

1. 13 MED 331, against V.S., for no violation
2. 13 MED 359, against (K.P.P., V.V.K.A., A.G. and C.A.M.), for no violation
3. 13 MED 366, against C.P. and T.A., for no violation
4. 13 MED 374, against M.W.J., for no violation
5. 14 MED 069, against D.B. and R.A.N., for no violation

Motion carried unanimously.

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

MOTION: Timothy Swan moved, seconded by Russell Yale, to affirm all motions made and votes taken in Closed Session. Motion carried unanimously.

DELEGATION OF RATIFICATION OF EXAMINATION RESULTS AND RATIFICATION OF LICENSES AND CERTIFICATES

MOTION: Greg Collins moved, seconded by Robert Zondag, to delegate ratification of examination results to DSPS staff and to ratify all licenses and certificates as issued. Motion carried unanimously.

ADJOURNMENT

MOTION: Michael Phillips moved, seconded by Greg Collins, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 10:37 A.M.



For Immediate Release: July 31, 2014

Contact: Drew Carlson

(817) 868-4043, dcarlson@fsmb.org

State medical boards launch educational effort to equip physicians for safe prescribing of opioid analgesics

Medical boards begin multi-state CME programming to provide health care professionals with latest knowledge on safe prescribing of extended-release and long-acting opioids

(Eules, Texas, July 31, 2014) – The Federation of State Medical Boards (FSMB) announced today that the nation’s state medical boards have kicked off a multi-state effort to educate health care professionals on the safe and responsible prescribing of extended-release (ER) and long-acting (LA) opioid analgesics for patients with chronic pain.

“We are very pleased that this important initiative to provide prescribers with the latest knowledge on the safe, responsible prescribing of opioid analgesics is underway,” said Humayun Chaudhry, DO, President and CEO of the FSMB. “State medical boards are ideally positioned to provide educational resources to help the licensees in their states learn safe, responsible prescribing of opioid analgesics.”

In collaboration with several partners, the FSMB and its philanthropic arm, the FSMB Foundation, received a Risk Evaluation and Mitigation Strategy (REMS) grant from the ER/LA Opioid Analgesics REMS Program Companies to provide educational programming in ER/LA prescribing to health care professionals. The grant provided resources for the FSMB and FSMB Foundation to award REMS grants to state medical boards to conduct free live seminars on ER/LA prescribing in their respective states, as well as free online continuing medical education resources at www.fsmb.org/safeprescribing. The collaboration is led by the University of Nebraska Medical Center and also includes partners CE City and the France Foundation.

The Louisiana State Board of Medical Examiners and the Arizona Board of Osteopathic Examiners in Medicine and Surgery recently became the first of 21 state medical board grant recipients to conduct live CME seminars. Grants were also awarded to the Alabama Board of Medical Examiners, Arizona Medical Board, Medical Board of California, Osteopathic Medical Board of California, Connecticut Medical Examining Board, District of Columbia Board of Medicine, Florida Board of Osteopathic Medicine, Georgia Composite Medical Board, Illinois Division of Professional Regulation, Iowa Board of Medicine, Maine Board of Licensure in Medicine, Nevada State Board of Medical Examiners, New York State Office of Professional Medical Conduct, North Carolina Medical Board, Oklahoma State Board of Osteopathic Examiners, Pennsylvania State Board of Medicine, Rhode Island Board of Medical Licensure and Discipline, South Dakota Board of Medical and Osteopathic Examiners, and Texas Medical Board.

The Food and Drug Administration has mandated that manufacturers of ER/LA opioid analgesics make available comprehensive prescriber education in the safe use of these medications, with the goal of reducing serious adverse outcomes resulting from inappropriate prescribing, misuse and abuse of these drugs – while maintaining patient access to pain medications. Given the broad spectrum of health care providers who prescribe opioids, the educational activities will be targeted to a multidisciplinary, interprofessional audience of prescribers. However, the primary audience for the program are clinicians who are registered with the DEA, eligible to prescribe Schedule 2 and 3 drugs, and have written at least one ER/LA opioid prescription in the past year.

Free CME available online: "Extended-Release and Long-Acting Opioids: Assessing Risks, Safe Prescribing"

In addition to the free, live seminars available under the grant, prescribers also have access to the educational curriculum via a free, online CME activity found at www.fsmb.org/safeprescribing. The "Extended-Release and Long-Acting Opioids: Assessing Risks, Safe Prescribing" activity qualifies for Continuing Medical Education AMA *PRA Category 1 Credit(s)*[™] and AOA Category 2B Credit(s).

About the program:

- Content based on the work of the nation's leading experts in opioid prescribing and patient risk assessment
- Free, user-friendly online webinar and other resources that can be accessed at any time
- Strong emphasis on better understanding opioid prescribing and building risk assessment into prescribing practices
- Six clinical-practice modules offer a consistent and reliable approach to safe prescribing

What prescribers will learn:

- How to appropriately assess patients for the treatment of pain with ER/LA opioid analgesics, including analyzing risks versus potential benefits
- How to assess patients' risk of abuse, including substance use and psychiatric history
- How to identify state and federal regulations on opioid prescribing
- Effective strategies for starting therapy, modifying dosing or discontinuing use of ER/LA opioid analgesics in patients with pain

- New ways of managing ongoing therapy with ER/LA opioid analgesics
- How to incorporate effective counseling of patients and caregivers
- Valuable product-specific drug information related to ER/LA opioid analgesics

How to participate:

To participate in this free online CME activity, please visit www.fsmb.org/safeprescribing. For more information about the program, contact the Federation of State Medical Boards at kalfred@fsmb.org or (817) 868-5160.

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About the Federation of State Medical Boards

The **Federation of State Medical Boards** (FSMB) is a national non-profit organization representing all medical boards within the United States and its territories that license and discipline allopathic and osteopathic physicians and, in some jurisdictions, other health care professionals. It assists these state and territorial medical boards as they go about their mandate of protecting the public's health, safety and welfare. The FSMB leads by promoting excellence in medical practice, licensure and regulation.

The **FSMB Foundation** is the philanthropic arm of the Federation of State Medical Boards. The Foundation's mission to promote research and education to improve the quality of health care through effective physician licensure and regulation. The FSMB Foundation undertakes educational and scientific research projects designed to expand public and medical professional knowledge and awareness of challenges impacting health care and health care regulation.

For more information about the FSMB and FSMB Foundation, please visit www.fsmb.org.

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Shawn Leatherwood, Administrative Rules Coordinator		2) Date When Request Submitted: July 9, 2014 Items will be considered late if submitted after 12:00 p.m. and less than: ■ 8 work days before the meeting	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: August 20, 2014	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Public Hearing on Clearinghouse Rule 14-040 relating to physicians and informed consent Review and respond to Clearinghouse Report and Public Hearing comments	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required: N/A	
10) Describe the issue and action that should be addressed: Hold Public Hearing at 8:30 AM Discuss any public hearing comments. Review, discuss and respond to any Clearinghouse comments.			
11) Signature of person making this request Shawn Leatherwood Supervisor (if required)		Authorization _____ Date July 9, 2014 _____ Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda) _____ Date			
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda-Deadline items must be authorized by a Supervisor and the Board Services Bureau Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			



**WISCONSIN LEGISLATIVE COUNCIL
RULES CLEARINGHOUSE**

Scott Grosz and Jessica Karls-Rupflinger
Clearinghouse Co-Directors

Terry C. Anderson
Legislative Council Director

Laura D. Rose
Legislative Council Deputy Director

CLEARINGHOUSE REPORT TO AGENCY

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

CLEARINGHOUSE RULE 14-040

AN ORDER to amend Med 18.02 (3), 18.04 (3) and (5), and 18.05; to repeal and recreate chapter Med 18 (title) and Med 18.03 (title); and to create Med 18.04 (6), relating to physicians and informed consent.

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

06-12-2014 RECEIVED BY LEGISLATIVE COUNCIL.

07-02-2014 REPORT SENT TO AGENCY.

JKR:AS

LEGISLATIVE COUNCIL RULES CLEARINGHOUSE REPORT

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

1. STATUTORY AUTHORITY [s. 227.15 (2) (a)]
Comment Attached YES NO
2. FORM, STYLE AND PLACEMENT IN ADMINISTRATIVE CODE [s. 227.15 (2) (c)]
Comment Attached YES NO
3. CONFLICT WITH OR DUPLICATION OF EXISTING RULES [s. 227.15 (2) (d)]
Comment Attached YES NO
4. ADEQUACY OF REFERENCES TO RELATED STATUTES, RULES AND FORMS [s. 227.15 (2) (e)]
Comment Attached YES NO
5. CLARITY, GRAMMAR, PUNCTUATION AND USE OF PLAIN LANGUAGE [s. 227.15 (2) (f)]
Comment Attached YES NO
6. POTENTIAL CONFLICTS WITH, AND COMPARABILITY TO, RELATED FEDERAL REGULATIONS [s. 227.15 (2) (g)]
Comment Attached YES NO
7. COMPLIANCE WITH PERMIT ACTION DEADLINE REQUIREMENTS [s. 227.15 (2) (h)]
Comment Attached YES NO



WISCONSIN LEGISLATIVE COUNCIL RULES CLEARINGHOUSE

Scott Grosz and Jessica Karls-Ruplinger
Clearinghouse Co-Directors

Terry C. Anderson
Legislative Council Director

Laura D. Rose
Legislative Council Deputy Director

CLEARINGHOUSE RULE 14-040

Comments

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

2. Form, Style and Placement in Administrative Code

a. In the introductory clause, “chapter Med 18 (title)” should be inserted before “Med 18.03” and the “(intro.)” following “Med 18.03” should be deleted.

b. In s. Med 18.02 (3), the underscored language should follow the stricken language. [s. 1.06 (1), Manual.] Therefore, “Modes of treatment” should be inserted after “~~modes of treatment~~”. Also in that subsection, “~~sued~~” should be replaced with “used”, and the comma following “procedures” should be underscored.

c. In the treatment clause for s. Med 18.03, “(title)” should be deleted since the entire section is repealed and recreated. In the title for s. Med 18.03, “Consent” should not be capitalized. [s. 1.05 (2) (b), Manual.]

d. In s. Med 18.04 (3), the first instance of “which is not” should not be stricken and the second instance of “which is not” should be deleted.

e. In s. Med 18.04 (6), a phrase such as “A physician is not required to communicate” should be inserted at the beginning of the sentence to be consistent with the other subsections.

STATE OF WISCONSIN
MEDICAL EXAMINING BOARD

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

PROPOSED ORDER

An order of the Medical Examining Board to amend Med 18.02 (3), 18.04 (3) and (5) and 18.05; to repeal and recreate Med 18.03 (title); and to create Med 18.04 (6), relating to physicians and informed consent.

Analysis prepared by the Department of Safety and Professional Services.

ANALYSIS

Statutes interpreted:

Section 448.30, Stats.

Statutory authority:

Sections 15.08 (5) (b), 227.11 (2) (a), and 448.40 (2) (a), Stats., 2013 Wisconsin Act 111

Explanation of agency authority:

Examining boards are authorized by s. 15.08 (5) (b), Stats., to promulgate rules that will provide guidance within their profession. Section 227.11 (2) (a), Stats., grants authority to boards to promulgate rules interpreting the statutes it enforces or administers as long as the proposed rule does not exceed proper interpretation of the statute. This proposed rule will interpret s. 448.30, Stats., which sets forth the guidelines physicians must follow in order to properly inform their patients regarding alternate modes of treatment. Section 448.40 (2) (a), Stats. grants express authority from the legislature to the Medical Examining Board to draft rules regarding informed consent.

Related statute or rule:

None.

Plain language analysis:

Recent legislation, 2013 Wisconsin Act 111, significantly impacted s. 448.30, Stats., and Wis. Admin Code s. Med 18. Before the Act, physicians had a duty to inform their

patients, under s. 448.30, Stats., of all alternate viable medical modes of treatment and about the benefits and risks of those treatments. After the passage of Act 111, physicians are required to inform their patients of reasonable alternate medical modes of treatment. The latter standard is not as broad as the former standard and in fact lessens the burden on physicians.

Another major change is the reasonable physician standard has replaced the reasonable patient standard. The reasonable physician standard requires doctors to disclose only the information that a reasonable physician in the same or similar medical specialty would know and disclose under the circumstances. The reasonable patient standard requires a physician to disclose information necessary for a reasonable person to make an intelligent decision with respect to the choices of treatment. The reasonable physician standard is a more objective approach and is the standard to which Wisconsin physicians must now adhere.

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

Several federal agencies, including but not limited to the Food and Drug Administration, have rules protecting human subjects participating in investigative trials. Investigators are required to obtain informed consent of each person that will participate in experimental studies, 21 CFR 50.20, including experiments involving drugs for human use found in 21 CFR 312.60. Obtaining informed consent from participants in the investigatory research is not intended to preempt any applicable federal, state, or local laws which require additional information to be disclosed in order for informed consent to be legally effective.

Comparison with rules in adjacent states:

Illinois: Illinois does not have a comparable statute or rule.

Iowa: Iowa statutes create a presumption that informed consent was given if it is documented in writing. "A consent in writing to any medical or surgical procedure or course of procedure in patient care which meets the requirements of this section shall create a presumption that informed consent was given." IOWA CODE § 147.137.

Michigan: Michigan's statute has comparable language which is directed towards physicians who are treating breast cancer patients. Physicians are required to inform patients verbally and in writing about alternative modes of treatment of cancer. The statute sets forth the reasonable physician standards. "A physician's duty to inform a patient under this section does not require disclosure of information beyond what a reasonably well-qualified physician licensed under this article would know." MCLS §333.17013 (6).

Minnesota: Minnesota does not have comparable statute or rule.

Summary of factual data and analytical methodologies:

No factual data was required for the rule-making in this proposal, due to the changes being necessitated by the passage of 2013 Wisconsin Act 111. For that reason, no factual data or analytical methodologies were used in the preparation of these proposed rules.

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

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

Fiscal Estimate and Economic Impact Analysis:

The Fiscal Estimate and Economic Impact Analysis are attached.

Effect on small business:

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

Agency contact person:

Shawn Leatherwood, Administrative Rules Coordinator, Department of Safety and Professional Services, Division of Policy Development, 1400 East Washington Avenue, Room 151, P.O. Box 8366, Madison, Wisconsin 53708; telephone 608-261-4438; email at Shancethea.L Leatherwood@wisconsin.gov.

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

Comments may be submitted to Shawn Leatherwood, Administrative Rules Coordinator, Department of Safety and Professional Services, Division of Policy Development, 1400 East Washington Avenue, Room 151, P.O. Box 8366, Madison, WI 53708-8935, or by email to Shancethea.L Leatherwood@wisconsin.gov. Comments must be received on or before August 20, 2014 to be included in the record of rule-making proceedings.

TEXT OF RULE

SECTION 1. Chapter Med 18 (title) is repealed and recreated to read:

CHAPTER MED 18 (title)
INFORMED CONSENT

SECTION 2. Med 18.02 (3) is amended to read:

Med 18.02 (3) ~~“Viable”~~ “Modes of treatment” as used in s. 448.30, Stats., to modify the term ~~“medical modes of treatment”~~ means modes of treatment means treatment, including diagnostic procedures, generally considered by the medical profession to be within the scope of current, acceptable standards of care.

SECTION 3. Med 18.03 (title) is repealed and recreated to read:

Med 18.03 (title) Informed Consent. Any physician who treats a patient shall inform the patient about the availability of reasonable alternate medical modes of treatment and about the benefits and risks of these treatments. The reasonable physician standard is the standard for informing a patient. The reasonable physician standard requires disclosure only of information that a reasonable physician in the same or a similar medical specialty would know and disclose under the circumstances.

SECTION 4. Med 18.04 (3) and (5) are amended to read:

Med 18.04 (3) A physician is not required to communicate any mode of treatment ~~which is not viable~~ which is not a reasonable alternate mode of treatment or which is experimental.

Med 18.04 (5) A physician may simplify or omit communication of ~~viable~~ reasonable alternate modes of treatment if the communication would unduly confuse or frighten a patient or if a patient refuses to receive the communication.

SECTION 5. Med 18.04 (6) is created to read:

Med 18.04 (6) Information about alternate medical modes of treatment for any condition the physician has not included in his or her diagnosis at the time the physician informs the patient.

SECTION 6. Med 18.05 is amended to read:

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

SECTION 7. EFFECTIVE DATE. The rules adopted in this order shall take effect on the first day of the month following publication in the Wisconsin Administrative Register, pursuant to s. 227.22 (2) (intro.), Stats.

(END OF TEXT OF RULE)

Dated _____

Agency _____

Chairperson
Medical Examining Board

ADMINISTRATIVE RULES Fiscal Estimate & Economic Impact Analysis

1. Type of Estimate and Analysis

Original Updated Corrected

2. Administrative Rule Chapter, Title and Number

Med 18

3. Subject

Informed consent

4. Fund Sources Affected

GPR FED PRO PRS SEG SEG-S

5. Chapter 20, Stats. Appropriations Affected

6. Fiscal Effect of Implementing the Rule

No Fiscal Effect Increase Existing Revenues Increase Costs
 Indeterminate Decrease Existing Revenues Could Absorb Within Agency's Budget
 Decrease Cost

7. The Rule Will Impact the Following (Check All That Apply)

State's Economy Specific Businesses/Sectors
 Local Government Units Public Utility Rate Payers
 Small Businesses (if checked, complete Attachment A)

8. Would Implementation and Compliance Costs Be Greater Than \$20 million?

Yes No

9. Policy Problem Addressed by the Rule

This proposed rule is a result of recent legislation. 2013 Wisconsin Act 111 changed the standard regarding doctors informing patients of their health care options by removing the reasonable patient standard and replacing it with the reasonable physician standard. The reasonable physician standard requires doctors to disclose only the information that a reasonable physician in the same or similar medical specialty would know and disclose under the circumstances. As a result of the legislation doctors must obtain informed consent from their patients by advising them of reasonable alternate medical modes of treatment and the benefits and risks of those treatments in a manner consistent with the reasonable physician standard. The proposed rule will update Wis. Admin. Code s. Med 18 to reflect these changes.

10. Summary of the businesses, business sectors, associations representing business, local governmental units, and individuals that may be affected by the proposed rule that were contacted for comments.

The Rule was posted on the Department and Professional Services website for 14 days in order to solicit comments from businesses, associations representing of Safety businesses, local governmental units and individuals that may be affected by the rule. No comments were received.

11. Identify the local governmental units that participated in the development of this EIA.

No local governmental units participated in the development of this EIA.

12. Summary of Rule's Economic and Fiscal Impact on Specific Businesses, Business Sectors, Public Utility Rate Payers, Local Governmental Units and the State's Economy as a Whole (Include Implementation and Compliance Costs Expected to be Incurred)

This proposed rule will not have a significant impact on specific businesses, business sectors, public utility rate payers, local governmental units or the state's economy as a whole.

13. Benefits of Implementing the Rule and Alternative(s) to Implementing the Rule

Physicians will advise their patients their patients in a manner of alternate modes of treatment in a manner that is consistent with current law. There is no alternative to implementing the proposed rule due to the changes being necessitated by passage of legislation.

ADMINISTRATIVE RULES

Fiscal Estimate & Economic Impact Analysis

14. Long Range Implications of Implementing the Rule

Physicians consistently advising patients of reasonable alternate medical modes of treatment will result in physicians upholding their duty to inform patients in accordance with s. 448.30, Stats.

15. Compare With Approaches Being Used by Federal Government

Several federal agencies, including but not limited to the Food and Drug Administration, have rules protecting human subjects participating in investigative trials. Investigators are required to obtain informed consent of each person that will participate in experimental studies, 21 CFR 50.20, including experiments involving drugs for human use found in 21 CFR 312.60. Obtaining informed consent from participants in the investigatory research is not intended to preempt any applicable federal, state, or local laws which require additional information to be disclosed in order for informed consent to be legally effective.

16. Compare With Approaches Being Used by Neighboring States (Illinois, Iowa, Michigan and Minnesota)

Illinois: Illinois does not have a comparable statute or rule.

Iowa: Iowa statutes create a presumption that informed consent was given if it is documented in writing. "A consent in writing to any medical or surgical procedure or course of procedure in patient care which meets the requirements of this section shall create a presumption that informed consent was given." IOWA CODE § 147.137.

Michigan: Michigan's statute has comparable language which is directed towards physicians who are treating breast cancer patients. Physicians are required to inform patients verbally and in writing about alternative modes of treatment of cancer. The statute sets forth the reasonable physician standards. "A physician's duty to inform a patient under this section does not require disclosure of information beyond what a reasonably well-qualified physician licensed under this article would know." MCLS §333.17013 (6).

Minnesota: Minnesota does not have comparable statute or rule.

17. Contact Name

Shawn Leatherwood

18. Contact Phone Number

608-261-4438

This document can be made available in alternate formats to individuals with disabilities upon request.

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Shawn Leatherwood, Administrative Rules Coordinator		2) Date When Request Submitted: August 4, 2014 <small>Items will be considered late if submitted after 12:00 p.m. and less than: ▪ 8 work days before the meeting</small>	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: August 20, 2014	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Review of Preliminary Rule Draft of Pod 4 Biennial Registration	
7) Place item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required: N/A	
10) Describe the issue and action that should be addressed: <p>Pursuant to Wis. Stats. §15.085 (5) (b) 1., the Board will review the preliminary draft of Pod 4 relating to biennial registration. The Board may make comments on the rule as well.</p>			
11) Shawn Leatherwood Signature of person making this request		Authorization August 4, 2014 Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Board Services Bureau Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

STATE OF WISCONSIN
PODIATRY AFFILIATED CREDENTIALING BOARD

IN THE MATTER OF RULEMAKING	:	PROPOSED ORDER OF THE
PROCEEDINGS BEFORE THE	:	PODIATRY AFFILIATED
PODIATRY AFFILIATED	:	CREDENTIALING BOARD
CREDENTIALING BOARD	:	ADOPTING RULES
	:	(CLEARINGHOUSE RULE)

PROPOSED ORDER

An order of the Podiatry Affiliated Credentialing Board to amend Pod 4.01 and 4.03(2), relating to biennial registration of podiatrists.

Analysis prepared by the Department of Safety and Professional Services.

ANALYSIS

Statutes interpreted:

Section 448.65 (2), Stats.

Statutory authority:

Sections 15.085 (b), 227.11 (2) (a) and 448.65 (2), Stats.

Explanation of agency authority:

Affiliated credentialing boards such as the Podiatry Affiliated Credentialing Board have the authority to promulgate rules that provide guidance within their profession pursuant to s. 15.085 (b), Stats. Boards are also authorized by s. 227.11 (2) (a), Stats., to set forth rules interpreting the provisions of any statute it enforces or administers. Section 448.65 (2), Stats., is administered by the Podiatry Affiliated Credentialing Board and provides guidance in the profession with regards to the requirements for podiatrists seeking renewal of their credential. The proposed rule seeks to amend the rules regarding renewal of a podiatrist's credential. Therefore, the Podiatry Affiliated Credentialing Board is empowered both generally and specifically to promulgate the proposed rules.

Related statute or rule:

Section 440.08 (2) (a) 60, Stats.

Plain language analysis:

The sole purpose of this proposed rule is to correct an inconsistency regarding the renewal date for podiatrists. Currently, s. Pod 4.01 and 4.03 state the renewal date for podiatrists is November 1 of each odd-numbered year while s. 440.08 (2) (a) 60, Stats., states that the renewal date is November 1 of each even-numbered year. The statute is controlling. Therefore, the proposed rule seeks to correct s. Pod 4.01 and 4.03 to reflect the correct date. There are no new policies proposed by the rule.

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

None.

Comparison with rules in adjacent states:

Illinois: Licenses issued in Illinois expire on January 31st of each odd-numbered year. A podiatrist may renew their license during the month preceding the expiration date. ILL. ADMIN. CODE tit. 68 §1360.55 a).

Iowa: Biennial license renewal for podiatrists is June 30th of each even-numbered year. Iowa Admin. Code r. 645-220.09 (1).

Michigan: Licensees must renew on an annual basis. MICH. ADMIN. CODE R 338.3701.

Minnesota: The renewal term begins on July 1st in odd-numbered years for a licensee whose license number is an odd number and in even-numbered years for a licensee whose license number is an even number. Minn. Rules. 6900.0200.

Summary of factual data and analytical methodologies:

None.

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

This rule will have a minimal or no effect on small businesses.

Fiscal Estimate and Economic Impact Analysis:

The Fiscal Estimate and Economic Impact Analysis are attached.

Effect on small business:

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

Agency contact person:

Shawn Leatherwood, Administrative Rules Coordinator, Department of Safety and Professional Services, Division of Policy Development, 1400 East Washington Avenue, Room 151, P.O. Box 8366 Madison, Wisconsin 53708-8366; telephone 608-261-4438; email at Shancethea.L Leatherwood@wisconsin.gov.

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

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

TEXT OF RULE

SECTION 1. Pod 4.01 is amended to read:

Pod 4.01 Registration required; method of registration. Each licensee shall register biennially with the board. Prior to November 1 of each ~~odd-numbered~~ even-numbered year the department shall mail to each licensee at his or her last known address an application form for registration. Each licensee shall complete the application form and return it with the required fee prior to November 1 of that year. The board shall notify the licensee within 30 business days of receipt of a completed registration form whether the application for registration is approved or denied

SECTION 2. Pod. 4.03 (2) is amended to read:

Pod 4.03 (2) Failure to renew a license by November 1 of ~~odd-numbered years~~ an even-numbered year shall cause the license to lapse. A licensee who allows the license to lapse may apply to the board for reinstatement of the license as follows:

SECTION 3. **EFFECTIVE DATE.** The rules adopted in this order shall take effect on the first day of the month following publication in the Wisconsin Administrative Register, pursuant to s. 227.22 (2) (intro.), Stats.

(END OF TEXT OF RULE)

Dated _____

Agency _____

Chairperson

Podiatry Affiliated Credentialing Board

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Shawn Leatherwood, Rules Coordinator		2) Date When Request Submitted: August 1, 2014 <small>Items will be considered late if submitted after 12:00 p.m. and less than: ▪ 8 work days before the meeting</small>	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: August 20, 2014	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? 2013 Wisconsin Act 114 and Wis. Admin Code Med 1	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required: N/A	
10) Describe the issue and action that should be addressed: The Board will discuss 2013 Wisconsin Act 114 and its impact on Wis. Admin Code Med 1.			
11) Signature of person making this request Shawn Leatherwood Supervisor (if required)		Authorization	Date August 1, 2014
<hr/> Bureau Director signature (indicates approval to add post agenda deadline item to agenda) _____ Date _____			
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Board Services Bureau Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

State of Wisconsin



2013 Senate Bill 337

Date of enactment: December 19, 2013
Date of publication*: December 20, 2013

2013 WISCONSIN ACT 114

AN ACT to repeal 449.05 (intro.), 451.06 (2), 452.09 (3) (e), 454.07 (3), 454.24 (3) and 456.04 (intro.); to renumber 442.04 (4) (a), 449.05 (1m), 449.05 (2m), 451.06 (1), 456.04 (1), 456.04 (2), 456.04 (3) and 456.04 (4); to renumber and amend 441.04, 441.06 (1), 441.07 (1), 441.10 (1), 441.10 (3) (a), 442.04 (4) (bm), 442.04 (4) (c), 442.04 (5), 449.04 (1), 450.03 (2), 450.04 (3) (intro.), 450.04 (3) (a), 450.04 (3) (b) and 456.03; to amend 39.393 (1) (c), 253.10 (7), 441.15 (3) (a) (intro.), 441.16 (2), 445.045 (1) (g), 449.04 (title), 449.055 (5) and 459.26 (3); to repeal and recreate 441.07 (title); and to create 440.071, 441.07 (1c), 441.10 (3) (a) 6. and 456.03 (5) of the statutes; relating to: examination requirements for various professional credentials and powers of the Board of Nursing.

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

SECTION 1. 39.393 (1) (c) of the statutes is amended to read:

39.393 (1) (c) A program in this state that confers a 2nd degree that will make the person eligible to sit for examination licensure under s. 441.04 441.06 or 441.10.

SECTION 2. 253.10 (7) of the statutes is amended to read:

253.10 (7) **AFFIRMATIVE DEFENSE.** No person is liable under sub. (5) or (6) or under s. 441.07 (1) (1g) (f), 448.02 (3) (a), or 457.26 (2) (gm) for failure under sub. (3) (c) 2. d. to provide the printed materials described in sub. (3) (d) to a woman or for failure under sub. (3) (c) 2. d., e., f., fm., or g. to describe the contents of the printed materials if the person has made a reasonably diligent effort to obtain the printed materials under sub. (3) (e) and s. 46.245 and the department and the county department under s. 46.215, 46.22, or 46.23 have not made the printed materials available at the time that the person is required to give them to the woman.

SECTION 3. 440.071 of the statutes is created to read:
440.071 No degree completion requirement to sit for examination. (1) Except as provided under sub. (2), the department or a credentialing board or other board in the department may not require a person to complete any postsecondary education or other program before the person is eligible to take an examination for a credential the department or credentialing board or other board in the department grants or issues.

(2) This section does not apply to an examination for a real estate appraiser certification under s. 458.06 or license under s. 458.08.

SECTION 4. 441.04 of the statutes is renumbered 441.06 (1) (a) and amended to read:

441.06 (1) (a) ~~Requisites for examination as a registered nurse.~~ Any person who has graduated The applicant graduates from a high school or its equivalent as determined by the board, ~~does.~~

(b) The applicant does not have an arrest or conviction record, subject to ss. 111.321, 111.322 and 111.335; ~~holds.~~

(c) The applicant holds a diploma of graduation from an accredited school of nursing and, if the school is

* Section 991.11, WISCONSIN STATUTES: 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."

Chapter Med 1

LICENSE TO PRACTICE MEDICINE AND SURGERY

Med 1.01	Authority and purpose.	Med 1.06	Panel review of applications; examinations required.
Med 1.015	Definitions.	Med 1.07	Conduct of examinations.
Med 1.02	Applications and credentials.	Med 1.08	Failure and reexamination.
Med 1.03	Translation of documents.	Med 1.09	Examination review by applicant.
Med 1.04	Application deadline.	Med 1.10	Board review of examination error claim.
Med 1.05	Fees.		

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

Med 1.01 Authority and purpose. The rules in this chapter are adopted by the medical examining board pursuant to the authority delegated by ss. 15.08 (5), 227.11, and 448.40, Stats., and govern application and examination for license to practice medicine and surgery under s. 448.04 (1) (a), Stats., (hereinafter "regular license").

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

Med 1.015 Definitions. As used in this chapter:

- (1) "FLEX" means the federated licensing examination.
- (2) "NBME" means the national board of medical examiners examination.
- (3) "USMLE" means the United States medical licensing examination.

History: Cr. Register, January, 1994, No. 457, eff. 2-1-94.

Med 1.02 Applications and credentials. Every person applying for regular license to practice medicine and surgery shall make application therefor on forms provided for this purpose by the board and shall submit to the board the following:

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

(3) A verified certificate showing satisfactory completion by the applicant of 12 months' postgraduate training in a facility approved by the board. The board recognizes as approved those facilities and training programs recognized as approved at the time of the applicant's service therein by the council on medical education of the American medical association, or the American osteopathic association, or the liaison committee on graduate medical education, or the national joint committee on approval of pre-registration physician training programs of Canada, or successors. If an applicant is a graduate of a foreign medical school not approved by the board and if such applicant has not completed

12 months' postgraduate training in a facility approved by the board, but such applicant has had other professional experience which the applicant believes has given that applicant education and training substantially equivalent, such applicant may submit to the board documentary evidence thereof. The board will review such documentary evidence and may make such further inquiry including a personal interview of the applicant as the board deems necessary to determine that such substantial equivalence in fact exists. The burden of proof of such equivalence shall lie upon the applicant. If the board finds such equivalence, the board may accept this in lieu of requiring that applicant to have completed 12 months' postgraduate training in a program approved by the board.

(4) An unmounted photograph, approximately 8 by 12 cm., of the applicant taken not more than 60 days prior to the date of application and bearing on the reverse side the statement of a notary public that such photograph is a true likeness of the applicant.

(5) A verified statement that the applicant is familiar with the state health laws and the rules of the department of health services as related to communicable diseases.

(6) The required fees made payable to the Wisconsin department of safety and professional services.

History: Cr. Register, October, 1976, No. 250, eff. 11-1-76; cr. (6), Register, February, 1997, No. 494, eff. 3-1-97; correction in (5) made under s. 13.93 (2m) (b) 6., Stats., Register, December, 1999, No. 528; correction in (5), (6) made under s. 13.92 (4) (b) 6., Stats., Register November 2011 No. 671; CR 13-090: am. (2) Register April 2014 No. 700, eff. 5-1-14.

Med 1.03 Translation of documents. If any of the documents required under this chapter are in a language other than English, the applicant shall also submit a verified English translation thereof, and the cost of such translation shall be borne by the applicant.

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

Med 1.04 Application deadline. The fully completed application and all required documents must be received by the board at its office not less than 3 weeks prior to the date of examination.

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

Med 1.05 Fees. The required fees must accompany the application, and all remittances must be made payable to the Wisconsin medical examining board.

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

Med 1.06 Panel review of applications; examinations required. (1) (a) All applicants shall complete the computer-based examination under sub. (3) (b), and an open book examination on statutes and rules governing the practice of medicine and surgery in Wisconsin. In addition, an applicant may be required to complete an oral examination if the applicant:

1. Has a medical condition which in any way impairs or limits the applicant's ability to practice medicine and surgery with reasonable skill and safety.

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Aaron Knautz- Licensing Exams Specialist		2) Date When Request Submitted: 8/8/14 <small>Items will be considered late if submitted after 12:00 p.m. on the deadline date: ▪ 8 business days before the meeting</small>	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: 8/20/14	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Determine if candidates are allowed to have a legal representative present during a Two Person Oral Exam administration.	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? <input checked="" type="checkbox"/> Yes (<u>Fill out Board Appearance Request</u>) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: <p>A candidate for a Two Person Oral Exam has requested for their legal representative to be present in the examination room during the administration of a Two Person Oral Exam. It is the Board's decision whether to allow their presence in the room during the examination. Please discuss and decide if a legal representative may be present during the Two Person Oral Examination.</p>			
11) Authorization			
 Signature of person making this request		8-8-14 Date	
 Supervisor (if required)		8-8-2014 Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda) Date			
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

BOARD APPEARANCE REQUEST FORM

Appearance Information

Board Name: Medical Examining Board

Board Meeting Date: 8/20/14

Person Submitting Agenda Request: Aaron Knautz

Person(s) requesting an appearance: Aaron Knautz

(NOTE: Contact information is not required for Department staff.)

Reason for Appearance: Discuss agenda item submission

Appearance Contact Information

(NOTE: If the appearing party is represented by an attorney skip the "Appearance Contact Information" section and complete the "Attorney Contact Information" section.)

Mailing address:

Email address:

Telephone #:

Attorney Contact Information

Attorney Name:

Attorney's mailing address:

Attorney's e-mail address:

Attorney's telephone #:

Considerations about allowing legal representation in the two person Oral Exam room

- The presence of the additional individual may either intentionally or inadvertently affect the questions asked by the examiners. This could affect the examiner's ability to obtain the information they need to properly evaluate the candidate.
- Exam security would be at risk by allowing an additional person in the room. While a legal representative could be required to complete a confidentiality agreement, it is possible that information regarding the exam could be communicated either knowingly or unknowingly by the representative to other prospective exam candidates. The allowance of additional people in the examination rooms increases the possibility for examination content being disseminated.
- Since the oral exams are currently tape recorded, the entire examination is available for review by a legal representative in the event that the exam candidate is denied licensure as part of the hearing process. There is no good reason to allow a legal representative to be present in the room during an exam administration; in fact the Board may risk information being disseminated regarding the two person oral exam content unnecessarily in the event that the candidate does not fail the examination. If the candidate does fail the two person oral exam they have recourse as the candidate may complete a full board oral examination with their legal representative in the room with them during the administration.
- The examination recording and results are already available for review by the candidate per the rules stated in MED 1.09 and we have permitted a candidate's legal representative to be present for that review. Again, all relevant information regarding the two person oral exam would be available to the candidate and legal representative at this step in the oral exam process.
- Industry standards do not typically allow for an additional individual to be present in an exam setting, as doing so may invalidate the exam results and places the exam content at risk of security breach.

8/8/14

David W. Florence, MD
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Hudson, WI 54016

July 16, 2014

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Sridhar Vasudevan, M.D., Secretary
WI Medical Examining Board
1400 E. Washington Ave.
P.O.Box 8935
Madison, WI, 53708-8935

Dear Sridhar,

Well it has been a long time since my days in chronic pain management, and I have now become one of the most senior orthopedic spine specialists in America, still working about ten hours a day at age 84, doing primarily IME's and record reviews plus functioning as a medical/legal consultant to industry and insurance companies.

I do review the publications of the Medical Board very carefully and am very pleased with your Prescription Drug Monitoring Program which I have found to be a very NEEDED entity in both Wisconsin and Minnesota. However, I also see a more covert issue and problem, and that is the abuse of epidural steroid injections, both interlaminar and foraminal. I am sure that you have seen the tip of the iceberg, but I am at the bottom of the ocean, looking up and I get a full view.

I have enclosed current peer-reviewed support articles plus my editorial in SPINELINE. I have received several notes of thanks for speaking out on the subject, but the peer-reviewed support articles are the cement for pointing out the issue and requesting remediation. I know that medical organizations and insurance companies are looking at rules and regulations, but I do feel that it would be more appropriate for the Board to be the Pioneer.

Hope that you are well and do keep in touch.



SpineLine welcomes Letters to the Editor in response to articles published in these pages, as well as on topics of relevance to NASS or its membership. Please address your letters to:

William Sullivan, MD

Letters to the Editor

SpineLine

North American Spine Society

7075 Veterans Boulevard

Burr Ridge, IL 60527

email c/o: ptowne@spine.org

SpineLine is also interested in stories about members' notable achievements including interests outside of their spine practices. If you or one of your spine colleagues is involved in an interesting activity, hobby, volunteer project or other effort, please let us know by emailing ptowne@spine.org.

Thank you.

To the Editor

Your November/December articles by Ralph F. Rashbaum, MD, and Donna D. Ohnmeiss, PhD, ("Psychology of the Spine Surgeon and other Spine Interventionalists") and Thomas Mroz, MD ("Empathy, Ethics and Professionalism: The Timeless Foundation of Our Collective Duty"), are classic examples of exactly one of the things they lament so loudly in their articles: hubris. If only all the other surgeons in the country were as ethical, consistent and successful as they were, the world would be a better place! (My overriding tone of this letter: sarcasm.)

Instead of lamenting all the unethical behavior amongst spine surgeons, they should dedicate more time to publishing peer-reviewed data that demonstrate superior outcomes to provide "best practice" guidelines for us lowly, regular spine surgeons in the United States. Instead of lamenting that physicians have developed alternative income streams that didn't exist "back in the day" when physicians only cared about their patients and not their own well-being (an assertion that is not true, coincidentally), perhaps they can eschew all alternative sources of income or benefits other than professional fees/salaries they receive for providing care. Instead of lamenting the excess of surgery performed, perhaps we can ask their permission on each patient to determine exactly which surgeries to perform and which ones not to perform.

I could go on for pages on the condescending nature of their statements and examples, but it serves no purpose. Suffice it to say that there are ways to draw attention to the over utilization of surgery without taking a patronizing tone and presumption of superiority, the latter of which I seriously doubt exists (from a professional or ethical standpoint) over the majority of surgeons in the United States.

Jonathan D. Sherman, MD

Eugene, OR

To the Editor

The November/December issue of **SpineLine** was excellent, and I truly ap-

preciated the commentary of Thomas Mroz, MD, on "Empathy, Ethics and Professionalism," typical of the excellence of the Cleveland Clinic and its medical/social outreach system with which I am familiar, having been on the adjunct staff during my time as Medical Director of the Industrial Commission of Ohio in the mid 80s.

Dr. Mroz pointed out the "heterogeneity in nonsurgical and surgical treatment of spine problems" plus the treatment disparity based on multiple parameters. The word "greed" was even stated. He did not hesitate to point out "undignified, unethical and unprofessional behavior by spine specialists" as significant issues. Dr. Mroz concluded by saying: "Our role in society is to serve people." What a wonderful presentation.

I next read the commentary by NASS President, William C. Watters III, MD, titled "That Ain't Right." Although there are similarities in the education of Dr. Watters and myself, there appear to be marked dichotomies in our conclusions, as my job at the present time is that of a medical/legal consultant to industry and insurance companies, and I see the other side of the coin, namely—the insurance companies are not the enemies, and the majority are ethical and ultimately generous in their decisions, when even on occasion I say "NO."

My thinking pattern may result from a life history including a lengthy career as an orthopedic surgeon, traumatologist, pain management specialist, health care administrator, spine & occupational medicine provider and, for the last decade, in spine and medical/legal work. A few of my findings over the last 10 years:

- Over 50% of the patients I see who have had back surgery are not better. I realize that I see the problems but even that figure is too high.
- I am unable to ascertain justification for over 80% of the injection procedures that I review.
- I cannot justify SI joint fusions, based not only on the literature but also on the teachings of Dr. Joseph Barr Sr. at the MGH.

So what and where is the problem?

Although the major medical facilities demonstrate high ethics and quality performance, some spine groups and individual spine practitioners simply do not.

One excuse might be the inability of the diagnostician to differentiate physical from psychological problems and treat each in accordance, or they may not wish to do so. It is also important to look at the brain as a pain generator, as

current peer-reviewed spine literature has made the issue paramount.

We all make mistakes, but exploitation of patients is not acceptable, either in medical or surgical care. We as physicians have a higher responsibility to honesty and integrity toward our patients. There is NO alternative.

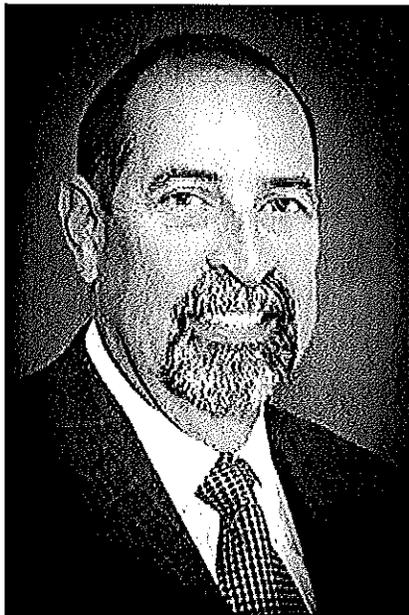
David W. Florence, MD, MAPA
Hudson, WI

Dr. Mroz and Dr. Sullivan Reply:

We thank Dr. Sherman and Dr. Florence for their comments. We appreciate their willingness to contribute these perspectives to the discussions raised in the November/December 2013 issue of *SpineLine*.

Tom Mroz, MD
Immediate Past *SpineLine* Editor

William Sullivan, MD
SpineLine Editor



Anthony Castellvi, MD
November 14, 1952 – February 8, 2014

In Memoriam
Anthony Castellvi, MD

By Roy Sanders, MD
Tampa, FL

Tony Castellvi, MD, our partner for over twenty years, will be sorely missed. He was a fixture in the Tampa Bay orthopedic community for over thirty years. First introduced to orthopedics by his father-in-law, Dr. Ortelio Rodriguez, he entered the residency in orthopedics at University of South Florida under Phillip Spiegel, MD, and fell in love with scoliosis surgery. So motivated, he finished a spine fellowship at the University of Rochester. Upon his return to Tampa, Tony began his career in private practice as a general orthopedist with an interest in spinal disorders and scoliosis. Very quickly, however, he became one of the premiere spine surgeons in Tampa Bay. Glenn Rechtine, MD, introduced Tony to the Florida Orthopaedic Institute (FOI), and once at FOI, he was able to focus his practice exclusively on spinal disorders. Tony ultimately became the senior FOI spine surgeon, and was instrumental in recruiting our spine faculty and the development of the FOI Spine program. His dedication to patient care and concern with lowering complications led him to bring the Mazur robot to Tampa.

Over the years, Tony was able to devote more and more time to his other passion; motion preservation. He became enamored with both spine research and spine education, realizing the need to make a difference in patient care. Never one to take a back seat, Tony started a spine fellowship at FOI and developed a research division at the Foundation for Orthopedic Research and Education (FORE). He began to publish his results regularly, and not only became a highly-sought lecturer and designer, but ran his annual Duck Key course which became a standard on the spine calendar.

Most of all, though, his patients loved him. They knew he always had their interests at heart and that he would always do the right thing. He was compassionate, caring and thoughtful. For his partners, he lived his life large, enjoying his family and everything around him. He was a consummate fisherman, duck and quail hunter, baseball fanatic and avid bicyclist. Anyone who knew him knew his infectious laugh, listened to his many hilarious stories and realized that they were in the presence of the "real" deal. His love of his wife, Ramona, and his three children was obvious to those who spent even a small amount of time with Tony. It was with great sadness that we learned of his passing. He was the best partner anyone could have: loyal to a fault, a true friend, a teacher, educator and outdoorsman, and most of all, a sincere and dedicated family man.

New Study Offers Insights on the Overuse of Spinal Injections and Other Interventional Pain Procedures

There appears to be gross overuse of interventional pain procedures for low back pain in the United States—from spinal injections to radiofrequency neurotomy. At least, the growth in these procedures is out of sync with the evidence on their clinical benefit.

The past decade has seen explosive growth in interventional procedures. For example, a 2009 study found a 543% increase in facet joint interventions among Medicare beneficiaries from 1997 to 2006. Overall, there was a 197% increase in the use of interventional pain services. (See Manchikanti et al., 2009.) This bulge in utilization comes at a steep cost at a time when medicine is trying to reduce the use of expensive unproven treatments. (See Friedly et al., 2007.)

One of the major questions in addressing this problem is whether there is broad or narrow overuse of these pain procedures. Do most interventional spine physicians perform an excessive number of procedures? Or is a small minority responsible for the lion's share of interventions?

It would obviously be easier to restrain the clinical behavior of a small number of practitioners than to alter broad treatment standards that cut across medical disciplines.

Study of 12 to 14 Million Patients

A recent study looked at this question and offers reassuring news. Venu Akuthota, MD, and colleagues studied utilization of interventional spine procedures in a claims database of 12 million to 14 million privately insured adults in the United States. (See Akuthota et al., 2010.) Coauthor Zach Abbott, MD, presented the study at the annual meeting of the North American Spine Society in Orlando.

They studied patients who had undergone epidural steroid injections, facet or medial branch blocks, radiofrequency neurotomy, and/or sacroiliac joint injections.

They focused on subjects who had an interventional spine procedure and 12 months of continuous claims data. They tallied the number of procedures that each individual had over a 12-month period within and across medical professions.

They then tallied the mean number of procedures per patient within and across medical specialties.

The results fell into a remarkably clear pattern. A minority of spine care providers accounted for the majority of interventional procedures. "The top 20% of utilizers accounted for 57.6% of all spinal procedures," according to Abbott. "The top 10% of utilizers performed 36.6% of the total spinal procedures performed."

Most medical providers appear to use interventions in moderation. The overall mean for all providers was 4.46 procedures for the 12-month inclusion period. The overall median number was two procedures.

But the range of utilization showed some extremes. For instance, the number of procedures performed on any individual patient over the course of 12 months ranged from one to 152.

During discussion of the study, moderator Stuart Weinstein, MD, queried Abbott over this figure. "Did I see the number 152?" asked Weinstein incredulously. "You had one patient who had 152 procedures in a year?"

"Yes, that was what was billed for," Abbott responded, to an audible "Wow" from another panel member.

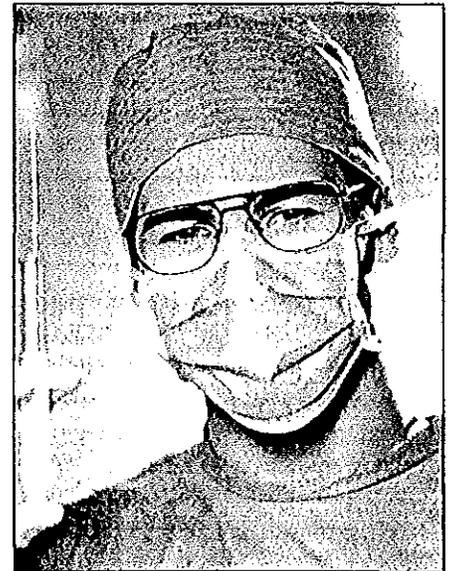
The range for epidural steroid injections (for an individual patient over the course of a year) was one to 51, that for facet or medial branch blocks was one to 135, that for radiofrequency neurotomy was one to 34, and that for sacroiliac joint injections one to 20.

Abbott et al. also tallied procedures by profession. Neurologists had the highest utilization, with an average of 4.81 procedures per year, followed by pain management specialists at 4.8 and radiologists at 2.29.

Overall Conclusions

Abbott believes that this study provides a good start for chipping away at this problem. What are his overall conclusions? "Relatively few providers are responsible for a disproportionately high percentage of interventional spine procedures. Although some variation in the utilization of procedures exists across specialties, a consistent pattern of marked overutilization by a minority of providers is the dominant characteristic of utilization within all specialties," he said.

The study would seem to point to viable intervention strategies. "Efforts to abate over-utilization of spinal intervention will



be most effective if they scrutinize the practices of those individuals, regardless of specialty, who are responsible for a disproportionately high number of spinal interventions," Abbott asserted.

Other studies suggest that there is substantial geographic variation in the use of injections and other procedures. For instance, Janna Friedly, MD, and colleagues found a 7.7-fold difference between states with the lowest and highest utilization of epidural steroid injections. (See Friedly et al., 2008.) So it may be possible to focus efforts on restraining the use of injections and other procedures within individual states or regions.

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Does the Growing Wave of Invasive Treatments Find Support in the Scientific Evidence?

Over the past two decades, physicians have directed an ever-growing arsenal of invasive treatments at annular tears, abnormal endplates, osteoarthritic facet joints, and other anatomic targets suspected of being sources of low back symptoms. Yet the unfortunate truth is that, in 2009, proven invasive cures for low back pain are few and between.

The American Pain Society (APS) recently sponsored two major reviews and a clinical practice guideline on invasive treatments for persistent low back pain. Roger Chou, MD, and colleagues performed meticulous systematic reviews of the evidence from randomized controlled trials (RCTs) on both surgical and non-surgical invasive procedures. A multidisciplinary guideline panel then offered a series of consensus statements based on that evidence. (See Chou et al., 2009[a]; Chou et al., 2009[b]; Chou et al., 2009[c].)

The evidence reviews found that most invasive pain procedures don't find strong support in high-quality clinical trials. And even those that appear to be beneficial shouldn't be regarded as panaceas.

The evidence base supporting invasive treatments for persistent low back pain without leg symptoms (i.e. nonradicular low back pain) is particularly weak.

Despite the claims of proponents, there is not a single proven invasive nonsurgical treatment for subacute or chronic low back pain—from injections to thermal therapies to intrathecal pain pumps.

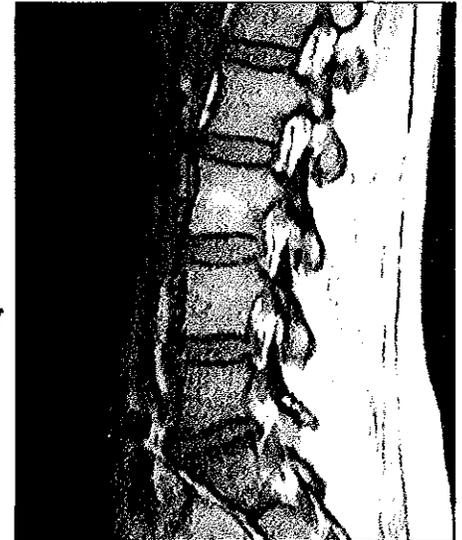
There is evidence in favor of fusion surgery for chronic nonradicular back pain in the presence of common degenerative changes on imaging scans. However, the reviewers found spinal fusion for nonradicular low back pain to be no more effective than intensive multidisciplinary rehabilitation with a cognitive behavioral orientation.

There is greater evidence in favor of invasive treatments for low back pain with

leg symptoms, particularly disc surgery for sciatica and decompression surgery with or without the addition of fusion for spinal stenosis. (See further description below.) However, even among patients with radicular back pain, many nonsurgical invasive treatments don't have proven benefits.

Health care providers often employ invasive diagnostic tests in an attempt to identify pain generators in the low back—and help target specific therapies. However, the APS reviewers couldn't find convincing evidence to support the use of any commonly employed invasive test—from discography to facet blocks to sacroiliac joint procedures.

Continued on page 64



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Spinal Loading And Back Pain

Health care providers are often asked to give their opinions regarding the role of spinal loading—particularly loading at work—in the development of low back pain.

A number of systematic reviews have concluded that heavy work, bending and twisting, whole-body vibration, and other physical exposures are risk factors for the development of low back pain. Some have even asserted that physical loading exposures are the dominant risk factors for the development of this common symptom.

Yet most prior reviews based their conclusions on epidemiologic studies of less than ideal methodological quality. And many researchers have wondered whether studies of higher quality would come to similar conclusions.

A new systematic review from the Netherlands by Eric W.P. Bakker, PhD, and colleagues set out to answer that question by looking at the results of high-quality prospective cohort studies. (See Bakker et al., 2009.)

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Spinal Injections: Are They Painful?

Young children approach injections with great trepidation. But with the aid of entertainment and distraction, the pain associated with injections is barely a bump in the road for most children.

But what about adults? Do they experience significant pain with injections—particularly diagnostic and therapeutic injections? No one really knows.

The last decade has seen a tsunami of injection procedures for spinal problems in the United States. Most types of spinal injections—both diagnostic and therapeutic—don't have a proven benefit in spine care, at least in terms of evidence from high-quality clinical trials. (See Chou et al., 2009.)

So one can argue that quantifying the risks and discomforts related to these injections should become a more important consideration. In other words, patients would be less likely to opt for an unproven procedure if they were informed that it involved significant pain.

However, the pain levels associated with routine injections haven't been studied thoroughly. This prompted French researchers to perform a recent cross-sectional national study of procedural pain associated with injections by rheumatologists. (See Perrot et al., 2010.)

Serge Perrot, MD, and colleagues evaluated the prevalence and intensity of pain caused by intra- and peri-articular injections, synovial fluid aspirations, soft tissue injections, and spinal injections. Knee problems were the indication for about half the injections, the spine for about 20%, the shoulder for 15%, and the small joints for 12%.

The researchers did not assess the skill levels of the physicians. But on average, the treating rheumatologists had a mean of over 20 years' experience in delivering injections. About half the patients received some form of analgesia.

There was also scant information on the details of the injections, i.e. whether they occurred under imaging guidance, in offices, or in hospitals.

"Over 80% of patients experienced procedural pain which was most common in the small joints (42%) and spine (32%)," according to Perrot and colleagues. Pain was severe in 5.3% of patients, moderate in 26.6%, mild in 49.8%, and absent for a lucky 18.3%.

Severe pain was most common among patients with severe pain complaints related to their underlying anatomic condition—and among individuals undergoing injections into small joints.

The study didn't provide much detail on the spinal procedures or the level of pain associated with them.

In many respects, this is a pilot study and a call for further research. The authors believe that pain associated with such commonly performed procedures should be studied more thoroughly and managed more carefully. They suggest that medical staff systematically underestimate the pain associated with such procedures or are sometimes completely unaware that they produce pain at all.

Most practitioners in the spine field don't regard pain associated with injections as a significant concern. And this consensus may be correct. However, some formal research to support or refute this view would certainly be welcome.

References:

- Chou R et al., Nonsurgical interventions for low back pain: A review of the evidence for an American Pain Society clinical practice guideline, *Spine*, 2009; 34:1078–93.
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Disc Surgery

Continued from page 43

Could the Postsurgical Period Be Crucial?

Atlas wonders whether patients on workers' compensation claims treated surgically might benefit from additional interventions in the period after surgery. "The short-term but not long-term relative benefit of surgery for those with workers' compensation claims suggests that the postoperative period may be critical," Atlas speculated in his e-mail.

Subjects on workers' compensation may face distinctive challenges after disc surgery as they recover from their radicular symptoms and face the prospect of resolving their compensation claims. Atlas would like to see more research in this area.

"It is possible that postoperative treatments may be more important in those with workers' compensation claims, and future research should focus on the expectations among individuals considering surgery as well as the intensity of postoperative rehabilitation among those who undergo surgery," said Atlas.

This is a vital area of research, said Atlas. "The spine research community should do more to study the work and disability outcomes of our patients," he asserted.

But in the meantime, said Atlas, health care providers shouldn't shy away from patients with workers' compensation claims. They need help in addressing their medical and work-related problems.

"Though there are many factors outside of our control, caring, competent clinicians still need to address the work-related impairments of our patients," Atlas added.

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Lumbosacral Injections: Where Is the Evidence They Are Beneficial?

Lumbosacral injections have become common—some would say standard—treatments for back problems in both middle-aged and older patients, despite a lack of high-quality scientific evidence demonstrating their value.

For example, in the Spine Patient Outcomes Research Trial (SPORT) randomized controlled trial on the treatment of lumbar disc herniations, 42% of (largely middle-aged) subjects had an epidural steroid injection prior to enrollment. And 56% of individuals who underwent nonoperative therapy in that trial had an injection over the course of the study. (See Weinstein et al., 2006.)

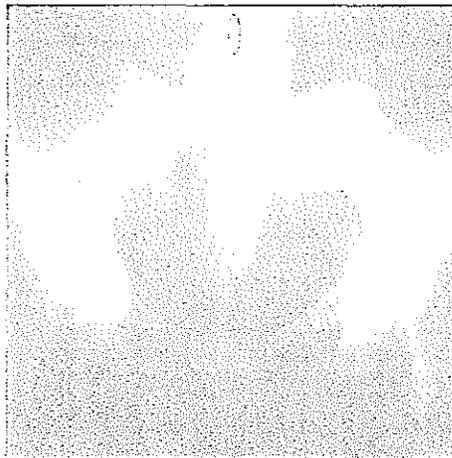
Among older patients receiving treatment for spinal stenosis in the degenerative spondylolisthesis wing of SPORT, 55% had an epidural injection prior to enrolling in the study. And 45% of those receiving nonoperative treatment in this wing had an epidural steroid injection during the study. (See Weinstein et al., 2007.)

The strongest evidence regarding the potential benefit of various types of epidural steroid injections comes from studies of the treatment of sciatica related to a disc herniation. But even here, the evidence is conflicting and equivocal.

For instance, a recent systematic review by the American Academy of Neurology (AAN) found little evidence that epidural steroid injections have a positive, long-term impact on patients with radicular pain. The review concluded that epidural steroid injections do not improve function, do not reduce the need for surgery, and do not provide long-term pain relief. (See Armon et al., 2007.)

The review concluded that epidural steroid injections do provide some short-term pain relief. But even this conclusion came with a caveat. "While some pain relief is a positive result in and of itself, the extent of leg and back pain relief from epidural steroid injections, on the average, fell short of the values typically viewed as clinically meaningful," said Carmel Armon, MD, lead author of the review in a statement issued by the AAN.

At least one recent systematic review has concluded that epidural steroid injections aren't a useful therapy for sciatica. A systematic review by Pim Luijsterburg, PhD, and colleagues could find no con-



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clusive evidence that steroid injections are effective over the long-term and did not recommend them as a treatment. (See Luijsterburg et al., 2007.)

Physicians commonly employ steroid injections as a treatment for spinal stenosis. Several small randomized controlled trials have examined the impact of steroid injections on patients with spinal stenosis or mixed groups of patients with either stenosis or a painful herniated disc. They do not provide convincing evidence that injections provide a long-term benefit. Case series have provided some hint that steroid injections might provide a short-term symptom advantage for patients with spinal stenosis, but this needs to be confirmed in randomized trials. (See North American Spine Society, 2007.)

The popularity of steroid injections for pain attributed to the facet joints has waxed and waned over the past two decades and seems to be waxing again. An article on page 100 of this issue discusses the evidence on facet joint injections. From a therapeutic viewpoint, the most important message is that there is no evidence from well-designed RCTs that steroid injections provide any long-term benefit.

Steroid injections for sacroiliac problems have also passed in and out of fashion over the years. Several small RCTs have evaluated steroid injections as treatments for spondyloarthropathies and sacroiliitis and provide only preliminary evidence that they might have a beneficial effect. (See Cohen SP et al., 2005; and Hansen HC et al., 2007.)

However, the most common indications for sacroiliac joint injections in the United States are back symptoms attributed to noninflammatory sacroiliac conditions, ranging from simple strains to sacroiliac degeneration. The efficacy of steroid injections for these conditions has never been evaluated in RCTs.

Steroid injections for these diagnoses find support only in small case series; and even here, the results haven't been entirely consistent. Given the difficulties and uncertainties attendant in the diagnosis of sacroiliac problems, no one should have confidence that this body of literature provides a convincing rationale for an invasive intervention.

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Clash Between Evidence-Based Medicine and Allegiance to Spinal Injections—With a Sad Outcome

Back pain experts who volunteer to take part in systematic reviews concerning the scientific evidence on low back pain usually do not have to look over their shoulders in fear of their professional societies.

Most participants understand that systematic reviews and related guideline development efforts follow a standardized method of identifying, analyzing, and rating the quality of randomized controlled trials (RCTs) and other studies.

Reviewers usually do not intend the final output to be a representation of their personal opinions but of the content of the underlying scientific evidence.

And most professional medical societies are supportive of the roles of their members

in these evidence-vetting efforts even if these organizations don't agree with the conclusions of the systematic reviews.

British Pain Society Breaks With Tradition

The British Pain Society recently broke with this genial scientific tradition and decided to oust its president, Paul Watson, PhD, for taking part in a systematic review and guideline effort on the early management of persistent nonspecific low back pain—and for not protesting the conclusions of the guideline regarding spinal injections.

As a report in the *BMJ* noted, “The president was forced to resign on 21 July after a campaign from members who were

unhappy with guidelines on the management of low back pain from the National Institute for Health and Clinical Excellence (NICE), which he helped develop.” (See Kmietowicz, 2009.)

This is a sad punishment for a distinguished health care professional who was simply following the dictates of a standardized evidence-gathering process.

The NICE panel, chaired by Martin Underwood, MD, was investigating the evidence on the management of persistent low back pain lasting for more than six weeks but less than a year. Readers can find the complete evidence document and a summary of the main recommendations of the NICE panel at the reference below. (See NICE, 2009.)

Opponents of Health Care Reform Glom Onto the UK Injection Controversy—Employing the “R” Word

In an increasingly vicious debate, opponents of health care reform in the United States have latched onto the controversy in the UK—viewing the NICE recommendation (see adjacent article) against the use of spinal injections for persistent nonspecific low back pain as an example of “socialized medicine” and “rationing.”

A headline at Spectator.org trumpets “Britain Balances Its Healthcare Budget on the Backs of the Sick—Literally.” (See Vadum, 2009.)

The prosaically titled website HotAir.com offered this comment: “In order to save £33 million [\$55.6 million U.S.], the British single-payer system will no longer give cortisone shots for nonspecific back pain despite the effectiveness of the treatment...” (See Morrissey, 2009.) The author alleged that the main goal of the NICE panel was to reduce National Health Service spending. “Its priority was to reduce its budget, not to ensure that patients have effective pain relief...they want to cut back by 95% on cortisone shots regardless of whether the shots are effective or the replacement treatments are not,” according to Morrissey.

Not to be outdone, the National Center for Policy Analysis (NCPA) offered some pur-

ple prose in its headline: “British Patients Forced to Live in Agony.” The article went on to speculate that steroid injections are effective. “Specialists say therapeutic injections using steroids can deaden nerve endings, can provide months or even years of respite from pain. Others fear that if funding is cut, tens of thousands of people, mainly the elderly and frail, will be left to suffer excruciating levels of pain or pay as much as £500 [about U.S. \$847] each for private treatment...” according to the article. (See NCPA, 2009.)

All of these articles make some basic mistakes. They misunderstand the NICE evidence-review and guideline-development process. It was not primarily an effort to reduce costs. Rather, it took a cold, hard look at the scientific evidence to identify effective treatments in the early management of persistent back pain. None of the articles come to grips with the fact that spinal injections for persistent nonspecific low back pain don't appear to be effective, based on the current evidence. There is no compelling evidence that these injections do indeed provide respite from “agonizing” or “excruciating” or even run-of-the-mill “moderate” back pain.

And they don't come to the grips with the fact that health care systems with lim-

ited budgets simply can't pay for every single back pain treatment. And this is not an issue that applies solely to socialized health care systems. No health care system in the United States underwrites every form of treatment for low back pain. In fact, few health care systems cover treatments that don't find support in the scientific evidence.

When a health care system declines to pay for an ineffective or unproven treatment, does this constitute rationing—or is it intelligent use of finite financial resources?

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The panel concluded, among many other things, that RCTs and systematic reviews do not provide evidence of the effectiveness of spinal injections for persistent nonspecific back pain. And the NICE panel recommended that the National Health Service not provide routine reimbursement for those injections.

Conclusions on Injections Not a Surprise

The NICE conclusions about the efficacy of spinal injections for persistent nonspecific low back pain do not come as a surprise. As readers of the *BackLetter* are aware, there is scant evidence that spinal injections are an effective treatment for nonspecific low back pain.

The American Pain Society guidelines on invasive treatments for low back pain by Roger Chou, MD, and colleagues recently concluded that there was moderate evidence that epidural steroid injections provide short-term pain relief for sciatica or radicular back pain but couldn't find any evidence that injections are an effective treatment for other forms of low back pain. (See Chou et al., 2009.) And even the evidence on steroid injections for sciatica is somewhat inconsistent.

The recent Cochrane Collaboration review didn't find any persuasive evidence of the benefit of spinal injections for subacute or chronic low back pain. (See Staal et al., 2009.)

NICE Decision Misguided?

However, despite the lack of evidence from RCTs, the British Pain Society protested the NICE decision. According to the *BMJ* article by Zosia Kmietowicz, "...the society said that NICE's guideline development group was 'misguided' for not considering evidence from cohort studies and clinical case series in deliberations on this and other treatments." Members of the British Pain Soci-

ety expressed concern that this policy would deny pain-relieving treatment to a significant number of individuals with low back pain.

Outrage From NICE

The British Pain Society decision prompted a letter of protest from the chairman of NICE and its clinical director. "The British Pain Society has made its president a scapegoat because some of its members refuse to accept that there is not the scientific evidence to support their interventions. It is a sad day for the freedom of experts to express views, [and support] evidence-based medicine and the ideals of the medical profession," according to Michael Rawlins, MD, and Peter Littlejohns, MD. (See Rawlins and Littlejohns, 2009.)

What About Considering Cohort Studies and Case Series?

The assertion by the British Pain Society that NICE should have considered the results of cohort studies and case series on spinal injections for nonspecific low back pain might sound reasonable to someone who is not familiar with the evidence on low back pain.

But if the NICE panel were to consider the results of cohort studies and case series for spinal injections, it would need to perform similar literature reviews for other back pain treatments. And the number of studies involved would challenge even the most ardent reviewer.

There are more than 200 treatments for chronic low back pain—and the number is rising almost by the day as new approaches wend their way into the medical literature. There are more than 1000 RCTs on treatments for back pain.

The number of cohort studies and case series cannot be easily estimated. However, a recent search at MEDLINE with the search term "back pain" produced 33,931 references. So the type of literature review that the British

Pain Society recommends would likely keep an expert panel locked up for years.

And if NICE decided to accept evidence from cohort studies and case series regarding spinal injections on the basis of case series and cohort studies, it would have to make similar allowances for nearly every treatment for low back pain. The net result would be a very liberal prescription of recommended treatments. And it would leave health care systems and payers with virtually no guidance on which of the 200-odd treatments and therapies they should underwrite.

Unfortunately, the British Pain Society's stance does not seem to be a practical response to the lack of evidence on spinal injections for persistent nonspecific low back pain.

A better approach would be for the members of the British Pain Society to design and conduct large, rigorous RCTs on injections for persistent, nonspecific low back pain and see if the society's faith in these injections is warranted.

References:

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There is scant evidence that spinal injections are an effective treatment for nonspecific low back pain.

**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: August 20, 2014	5) Attachments: x Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Informational Items	
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: For informational purposes only.			
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	

Maintenance of certification took center stage at AMA Congress of Delegates

By: ALICIA AULT, Skin & Allergy News Digital Network

JUNE 24, 2014

AT THE AMA HOD MEETING

CHICAGO – The American Medical Association should continue to work with the American Board of Medical Specialties to address physicians' concerns about Maintenance of Certification – that was the consensus at the annual meeting of the AMA House of Delegates.

The AMA's delegates defeated a resolution that asked the organization to put a moratorium on MOC until it was proven to improve the quality of care and patient outcomes. However, they did agree to a new policy that directs the AMA to:

- Explore with independent entities the feasibility of conducting a study to evaluate the effect MOC requirements and Maintenance of Licensure principles have on workforce, practice costs, patient outcomes, patient safety, and patient access.
- Work with the American Board of Medical Specialties and its 24 member boards to collect data on why physicians choose to maintain or discontinue their board certification.
- Work with the ABMS and the Federation of State Medical Boards to study whether MOC and the principles of Maintenance of Licensure are important factors to physicians when deciding whether to retire and whether they have a direct effect on workforce.
- Oppose making MOC mandatory as a condition of medical licensure, and encourage physicians to strive constantly to improve their care of patients by the means they find most effective.

The new policy applies to both the ABMS MOC process and the Osteopathic Continuous Certification (OCC) process.

Physicians have increasingly voiced their concerns about MOC. Dr. Paul Teirstein, chief of cardiology and director of interventional cardiology for Scripps Clinic in La Jolla, Calif., launched

a petition drive to overhaul the American Board of Internal Medicine's MOC process. The petition has more than 17,000 signatures.

The ABIM says that it is listening to physicians and is making changes in the process, but also recently said that more than 150,000 physicians had participated in its MOC process – making the May 1 deadline to be listed on the ABIM website as having met the MOC criteria.

But anger is still bubbling up, and was expressed at the AMA's meeting.

"Practicing physicians on the front lines are increasingly burdened, hassled, and confused by the onerous and expensive process of Maintenance of Certification and Maintenance of Licensure," said Dr. James A. Goodyear, a delegate from Pennsylvania.

Dr. Goodyear introduced the resolution to seek a moratorium on the MOC.

But Dr. Darlyne Menscer, a member of the AMA Council on Medical Education, told the delegates that such a moratorium would put a wedge in the close working relationship the AMA has had with the ABMS. "This is more prescriptive than we can commit to as a council, although we definitely do hear the concerns of the House," added Dr. Menscer.

The AMA has been discussing the concerns about MOC with the ABMS, most recently holding a meeting in Chicago in early June.

Dr. Joshua Cohen, a delegate from the American Academy of Neurology, and a member of the AMA Foundation's Board of Directors, who attended that meeting, also argued against a moratorium. "It would make it impossible for the AMA to improve the process going forward," said Dr. Cohen.

Dr. Chuck Wilson, a pediatrician and delegate from the North Carolina delegation, also opposed any major change in direction for the AMA. He noted that if the AMA was seen as opposed to MOC, it might not be viewed well. "We all want it to be less onerous," said Dr. Wilson. But, he noted, "the Council on Medical Education is working in that direction. Let's give them a chance to be successful."

In a statement after the HOD meeting, the AMA said that it "continues to ensure the MOC process does not disrupt physician practice or reduce the capacity of the overall physician workforce." Concerns about MOC "center around the need for relevance to the daily practice of physicians and the better integration into physician practices to optimally support learning and improvement."

Changes to USMLE® 2014 - 2015

As medicine and medical education have changed over the years, so have USMLE examinations evolved

since they were first administered in 1992. This is a brief summary of planned changes for the next few

years.

USMLE STEP 3 -- What WILL change?

Beginning November 3, 2014, examinees will:

- Be able to take the exam on two consecutive or non-consecutive days;
- NOT need to apply for Step 3 under the eligibility requirements of a specific medical licensing authority;
- See increased numbers of items that assess an expanded range of competency-based content, including foundational science essential for effective healthcare; biostatistics, epidemiology, and population health; literature interpretation; medical ethics; and patient safety.

The two exam days will be named Step 3 Foundations of Independent Practice (FIP) and Step 3 Advanced Clinical Medicine (ACM).

USMLE STEP 3 -- What WILL NOT change?

The Step 3 exam will continue to:

- Focus on knowledge and application of the biomedical and clinical sciences necessary for independent patient care;
- Include multiple-choice questions and computer-based case simulations;
- Be administered over two days, for a total time comparable to current testing time;
- Result in a single score (with graphical performance profile

information) and a single pass/fail outcome after completion of both examination days.

Be administered at Prometric test centers throughout the United States.

Important to Note

Applications for the current Step 3 examination will not be accepted after 5:00 p.m.

(U.S. Central Time) on July 18, 2014.

Applications for the restructured Step 3 examination will be accepted starting on August 4, 2014.

No Step 3 examinations will be administered during most or all of October 2014.

Administration of the restructured Step 3 exam will begin on November 3, 2014.

There will be a score delay following introduction of the restructured Step 3 examination on November 3, 2014. The duration of the score delay will be determined by examinee volume during the early months of exam administration. Based on historic trends, we estimate that scores for Step 3 exams taken on or after November 3, 2014 will be released in April 2015.

Test date availability will be influenced by conditions at each Prometric test center; advance planning will enhance scheduling options.

USMLE STEP 2 Clinical Knowledge (CK) -- What WILL change?

In 2014 and 2015, examinees will see an increased focus on quality improvement principles; safety science; epidemiology, biostatistics, and population health; professionalism; and interpersonal and communications skills. These may be tested using item formats currently under development. If new item types are introduced into the examination, sample materials will be available on the USMLE website for examinees to review well in advance.

USMLE STEP 2 Clinical Knowledge (CK) -- What WILL NOT change?

Step 2 CK will continue to focus on patient care and diagnosis. The format will continue to be a computer-administered examination, using multiple-choice questions.

USMLE STEP 2 Clinical Skills (CS) -- What WILL change?

Further enhancements to the assessment of communications skills are being piloted. If the pilots are successful, these enhancements to Step 2 CS will be introduced into the exam no earlier than 2015, and will be announced well in advance.

USMLE STEP 2 Clinical Skills (CS) -- What WILL NOT change?

Step 2 CS will continue to focus on examinees' ability to gather information from patients, perform physical examinations, and communicate their findings to patients and colleagues. The examination will continue to use standardized patients to simulate patient encounters.

USMLE STEP 1 -- What WILL change?

In 2014 and 2015, examinees will see an increased focus on quality improvement principles and safety science.

USMLE STEP 1 -- What WILL NOT change?

Step 1 will continue to focus on traditional content areas in the basic sciences within a clinical context. The format will continue to be a computer-administered examination, using multiple-choice questions.

Important Note: Dates are subject to change. This fact sheet will be updated as new information becomes

available. Please check the USMLE website (www.usmle.org) frequently.

More Information: Additional information, including a timeline of key dates for changes to Step 3, is available on

the USMLE website at www.usmle.org/cru/. To receive updates as they become available, subscribe to the

USMLE Announcements RSS feed at <http://www.usmle.org/announcements/>.