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Tony Evers, Governor
Dawn B. Crim, Secretary

VIRTUAL/TELECONFERENCE
MEDICAL EXAMINING BOARD
Virtual, 4822 Madison Yards Way, Madison
Contact: Tom Ryan (608) 266-2112
June 15, 2022

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 May 18, 2022 (6-10)

C. Introductions, Announcements and Recognition

D. Reminders: Conflicts of Interest, Scheduling Concerns

E. Administrative Matters – Discussion and Consideration

1) Department, Staff and Board Updates
2) Board Members – Term Expiration Dates
   a. Bond, Jr., Milton – 7/1/2023
   b. Chou, Clarence P. – 7/1/2023
   c. Ferguson, Kris – 7/1/2025
   d. Gerlach, Diane M. – 7/1/2024
   e. Goel, Sumeet K. – 7/1/2023
   f. Lerma, Carmen – 7/1/2024
   g. Parish, Michael A. – 7/1/2023
   h. Sattler, Rachel E. – 7/1/2024
   i. Schmeling, Gregory J. – 7/1/2025
   j. Siebert, Derrick R. – 7/1/2025
   k. Wasserman, Sheldon A. – 7/1/2023
   l. Yerby, Lemuel G. – 7/1/2024
   m. Yu, Emily S. – 7/1/2024
3) Appointments, Reappointments, Confirmations, and Committee, Panel and Liaison Appointments
4) Assignment of Screening Panel and Examination Panel Liaisons
5) Wis. Stat. § 15.085 (3)(b) – Affiliated Credentialing Boards' Biannual Meeting with the Medical Examining Board to Consider Matters of Joint Interest
   a. Physician Assistant Affiliated Credentialing Board – Jennifer Jarrett, Chairperson

F. Professional Assistance Procedure (PAP) Presentation – Discussion and Consideration (11-62)

G. Legislative and Policy Matters – Discussion and Consideration

H. Administrative Rule Matters – Discussion and Consideration (63)

1) Status Update: Cos 2, 3, 5, & 8
2) Med 13, Relating to Continuing Medical Education **(64-67)**
3) Pending or Possible Rulemaking Projects
    a. Rules Projects Chart **(68)**

I. Federation of State Medical Boards (FSMB) Matters – Discussion and Consideration

J. Newsletter Matters – Discussion and Consideration

K. COVID-19 – Discussion and Consideration

L. Controlled Substances Board Report

M. Interstate Medical Licensure Compact Commission (IMLCC) – Report from Wisconsin's Commissioners – Discussion and Consideration

N. Screening Panel Report

O. Future Agenda Items

P. Discussion and Consideration of Items Added After Preparation of Agenda:

1) Introductions, Announcements and Recognition
2) Elections, Appointments, Reappointments, Confirmations, and Committee, Panel and Liaison Appointments
3) Administrative Matters
4) Election of Officers
5) Appointment of Liaisons and Alternates
6) Delegation of Authorities
7) Education and Examination Matters
8) Credentialing Matters
9) Practice Matters
10) Legislative and Policy Matters
11) Administrative Rule Matters
12) Liaison Reports
13) Board Liaison Training and Appointment of Mentors
14) Informational Items
15) Division of Legal Services and Compliance (DLSC) Matters
16) Presentations of Petitions for Summary Suspension
17) Petitions for Designation of Hearing Examiner
18) Presentation of Stipulations, Final Decisions and Orders
19) Presentation of Proposed Final Decisions and Orders
20) Presentation of Interim Orders
21) Petitions for Re-Hearing
22) Petitions for Assessments
23) Petitions to Vacate Orders
24) Requests for Disciplinary Proceeding Presentations

25) Motions
26) Petitions
27) Appearances from Requests Received or Renewed
28) Speaking Engagements, Travel, or Public Relation Requests, and Reports

Q. Public Comments

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

R. Deliberation on DLSC Matters

1) Proposed Stipulations, Final Decisions and Orders

a. 19 MED 249 – John P. Kiser, M.D. **(69-75)**
b. 19 MED 252 – Abd G. El-Khatib, M.D. **(76-81)**
c. 21 MED 161 – Julie A. Bulkow, R.C.P. **(82-92)**
d. 21 MED 490 – Kyle Greiber, M.D. **(93-98)**
e. 21 MED 536 – Jennifer N. Klopfstein, M.D. **(99-106)**
f. 22 MED 054 – Todd A. Nelson, M.D. **(107-117)**

2) Proposed Stipulation and Interim Order

a. 21 MED 216 – Farid A. Ahmad, M.D. **(118-123)**

3) Administrative Warnings

a. 21 MED 249 – S.T.M. **(124-125)**

4) Case Closings

a. 20 MED 092 – F.A.A. **(126-137)**
b. 20 MED 285 – F.A.A. **(138-145)**
c. 21 MED 256 – T.E.V. **(146-152)**
d. 21 MED 257 – D.R.N. **(153-156)**
e. 21 MED 412 – J.J.M. **(157-168)**
f. 21 MED 481 – C.T.P. **(169-176)**
g. 21 MED 496 – G.M. **(177-181)**
h. 22 MED 015 – Z.S., J.S. **(182-189)**
i. 22 MED 055 – T.A.L. **(190-229)**
j. 22 MED 119 – J.K.C. **(230-235)**
k. 22 MED 124 – B.E.R., P.A.S., M.E.K. **(236-245)**

5) Monitoring Matters (246-247)

a. Dr. David J. Kuester – Requesting Reduction in Daily Check-ins with Drug Monitoring Program from Daily to Bi-Weekly, Increase from Five (5) to Fourteen (14) Days to Produce a Specimen for Drug Testing, Reduction in Drug Test Frequency to No More than Twelve (12) Times Per Year, and Elimination of Professional Mentor Requirements **(248-275)**
b. Dr. John C. Wynsen – Requesting Full Licensure **(276-292)**

S. Credentialing Matters

1) Full Board Oral Interviews

a. **APPEARANCE:** David Stein, Medicine and Surgery (MD) Renewal Applicant **(293-299)**
b. **APPEARANCE:** James Rowe, Medicine and Surgery (MD) Applicant **(300-451)**
c. **APPEARANCE:** Patricia White, Medicine and Surgery (MD) Renewal Applicant **(452-459)**

2) Waiver of the 24-months of ACGME/AOA Approved Post-Graduate Training

a. Marcelo Bigarello, Medicine and Surgery (MD) Applicant **(460-521)**

T. Deliberation of Items Added After Preparation of the Agenda
1) Education and Examination Matters
2) Credentialing Matters
3) DLSC Matters
4) Monitoring Matters
5) Professional Assistance Procedure (PAP) Matters
6) Petitions for Summary Suspensions
7) Petitions for Designation of Hearing Examiner
8) Proposed Stipulations, Final Decisions and Order
9) Proposed Interim Orders
10) Administrative Warnings
11) Review of Administrative Warnings
12) Proposed Final Decisions and Orders
13) Matters Relating to Costs/Orders Fixing Costs
14) Complaints
15) Case Closings
16) Board Liaison Training
17) Petitions for Extension of Time
18) Petitions for Assessments and Evaluations
19) Petitions to Vacate Orders
20) Remedial Education Cases
21) Motions
22) Petitions for Re-Hearing
23) Appearances from Requests Received or Renewed

U. Open Cases

V. Consulting with Legal Counsel

RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION

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

X. Open Session Items Noticed Above Not Completed in the Initial Open Session

Y. Delegation of Ratification of Examination Results and Ratification of Licenses and Certificates

ADJOURNMENT

ORAL INTERVIEWS OF CANDIDATES FOR LICENSURE

VIRTUAL/TELECONFERENCE

10:00 A.M. OR IMMEDIATELY FOLLOWING THE FULL BOARD MEETING

CLOSED SESSION – Reviewing Applications and Conducting Oral Interviews of **one** (**1**) (at time of agenda publication) Candidates for Licensure – **Dr. Parish** and **Dr. Schmeling**

NEXT MEETING: JULY 20, 2022

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MEETINGS AND HEARINGS ARE OPEN TO THE PUBLIC, AND MAY BE CANCELLED WITHOUT NOTICE.

Times listed for meeting items are approximate and depend on the length of discussion and voting. All meetings are held at 4822 Madison Yards Way, Madison, Wisconsin, unless otherwise noted. In order to confirm a meeting or to request a complete copy of the board's agenda, please call the listed contact person. The board may also consider materials or items filed after the transmission of this notice. Times listed for the commencement of disciplinary hearings may be changed by the examiner for the convenience of the parties. Requests for interpreters for the deaf or hard of hearing, or other accommodations, are considered upon request by contacting the Affirmative Action Officer at 608-266-2112, or the Meeting Staff at 608-266-5439.

MEDICAL EXAMINING BOARD
MEETING MINUTES
MAY 18, 2022

PRESENT: Milton Bond, Jr., Clarence Chou, M.D.; Kris Ferguson, M.D.; Sumeet Goel, D.O.; Carmen Lerma; Michael Parish, M.D.; Rachel Sattler *(via Zoom)*; Gregory Schmeling, M.D.; Derrick Siebert, M.D. *(excused at 12:00 p.m./rejoined via Zoom at 12:04 p.m.)*; Sheldon Wasserman, M.D.; Lemuel Yerby, M.D. *(via Zoom)*; Emily Yu, M.D.

EXCUSED: Diane Gerlach, D.O.

STAFF: Tom Ryan, Executive Director; Jameson Whitney, Legal Counsel; Nilajah Hardin, Administrative Rules Coordinator; Kimberly Wood, Program Assistant Supervisor-Adv.; and other Department staff

CALL TO ORDER

Sheldon Wasserman, Chairperson, called the meeting to order at 8:13 a.m. A quorum was confirmed with eleven (11) members present.

(Lemuel Yerby joined the meeting at 8:16 a.m.)

ADOPTION OF AGENDA

MOTION: Michael Parish moved, seconded by Sumeet Goel, to adopt the Agenda as published. Motion carried unanimously.

APPROVAL OF MINUTES OF APRIL 20, 2022

MOTION: Clarence Chou moved, seconded by Emily Yu, to approve the Minutes of April 20, 2022 as published. Motion carried unanimously.

APPEARANCE: SECRETARY DAWN B. CRIM, DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

MOTION: Kris Ferguson moved, seconded by Sumeet Goel, to acknowledge and thank Dawn B. Crim, Secretary, Dept. of Safety and Professional Services, for joining the meeting. Motion carried unanimously.

APPEARANCE: DAN HERETH, ASSISTANT DEPUTY SECRETARY, DSPS LICENSE DEMONSTRATION

MOTION: Michael Parish moved, seconded by Derrick Siebert, to acknowledge and thank Dan Hereth, Assistant Deputy Secretary, Dept. of Safety and Professional Services, for his presentation on LicensE and for appearing before the Board. Motion carried unanimously.

CLOSED SESSION

MOTION: Clarence Chou moved, seconded by Sumeet Goel, 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.). Sheldon Wasserman, Chairperson, read the language of the motion aloud for the record. The vote of each member was ascertained by voice vote. Roll Call Vote: Milton Bond, Jr.-yes; Clarence Chou-yes; Kris Ferguson-yes; Carmen Lerma-yes; Sumeet Goel-yes; Michael Parish-yes; Rachel Sattler-yes; Gregory Schmeling-yes; Derrick Siebert-yes; Sheldon Wasserman-yes; Lemuel Yerby-yes; and Emily Yu-yes. Motion carried unanimously.

The Board convened into Closed Session at 10:59 a.m.

DELIBERATION ON DIVISION OF LEGAL SERVICES AND COMPLIANCE (DLSC) MATTERS

Proposed Stipulations, Final Decisions and Orders

19 MED 044 – Steven E. Bondow, M.D.

MOTION: Derrick Siebert moved, seconded by Gregory Schmeling, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Steven E. Bondow, M.D., DLSC Case Number 19 MED 044. Motion carried unanimously.

20 MED 304 – Luann Moraski, D.O.

MOTION: Kris Ferguson moved, seconded by Gregory Schmeling, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Luann Moraski, D.O., DLSC Case Number 20 MED 304. Motion carried unanimously.

(Derrick Siebert was excused at 12:00 p.m.)

20 MED 365 – Christopher A. Guite, M.D.

MOTION: Sumeet Goel moved, seconded by Emily Yu, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Christopher A. Guite, M.D., DLSC Case Number 20 MED 365. Motion carried unanimously.

21 MED 439 – Joel H. Blumin, M.D.

MOTION: Michael Parish moved, seconded by Clarence Chou, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Joel H. Blumin, M.D., DLSC Case Number 21 MED 439. Motion carried unanimously.

(Derrick Siebert connected via Zoom at 12:04 p.m.)

22 MED 117 – Edward W. Draper, M.D.

MOTION: Milton Bond moved, seconded by Carmen Lerma, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Edward W. Draper, M.D., DLSC Case Number 22 Med 117. Motion carried unanimously.

Administrative Warnings

21 MED 367 – K.L.G.

MOTION: Sumeet Goel moved, seconded by Milton Bond, to issue an Administrative Warning in the matter of K.L.G., DLSC Case Number 21 MED 367. Motion carried unanimously.

21 MED 374 – G.T.B.

MOTION: Michael Parish moved, seconded by Kris Ferguson, to issue an Administrative Warning in the matter of G.T.B., DLSC Case Number 21 MED 374. Motion carried unanimously.

21 MED 424 – L.A.S.

MOTION: Clarence Chou moved, seconded by Milton Bond, to issue an Administrative Warning in the matter of L.A.S., DLSC Case Number 21 MED 424. Motion carried unanimously.

Case Closings

MOTION: Gregory Schmeling moved, seconded by Clarence Chou, to close the following DLSC Cases for the reasons outlined below:

1. 19 MED 372 – J.E.H. – Prosecutorial Discretion (P5)
2. 19 MED 448 – G.C.N. – Prosecutorial Discretion (P2)
3. 19 MED 469 – D.I.S. – Prosecutorial Discretion (P1)
4. 21 MED 104 – S.E.R. – Insufficient Evidence
5. 21 MED 182 – J.G.D. – Prosecutorial Discretion (P1)
6. 22 MED 020 – M.A.M. – No Violation

Motion carried unanimously.

21 MED 446 – D.R.P.

MOTION: Gregory Schmeling moved, seconded by Clarence Chou, to close DLSC Case Number 21 MED 446, against D.R.P., for Prosecutorial Discretion (P1). Motion carried unanimously.

21 MED 450 – M.I.H.

MOTION: Sumeet Goel moved, seconded by Gregory Schmeling, to close DLSC Case Number 21 MED 450, against M.I.H., for No Violation. Motion carried unanimously.

Monitoring Matters

Nosheen Hasan, M.D. – Request for Full Licensure

MOTION: Sumeet Goel moved, seconded by Gregory Schmeling, to grant the request of Nosheen Hasan, M.D., for full licensure. Motion carried unanimously.

CREDENTIALING MATTERS

Full Board Oral Interview

George Butler, Medicine and Surgery (MD) Applicant

MOTION: Derrick Siebert moved, seconded by Michael Parish, to issue an intent to deny the license application of George Butler, and to offer him a limited license requiring him to comply with his Ohio order. **Reasons for denial**: Unprofessional conduct including failure to cooperate with an investigation of the Ohio Board, practice while impaired by use of alcohol, and having a license or credential revoked by another jurisdiction. Motion carried unanimously.

Application Review

James Rowe, Medicine and Surgery (MD) Applicant

MOTION: Milton Bond moved, seconded by Carmen Lerma, to table the Medicine and Surgery application of James Rowe and to require completion of a full board oral interview. Motion carried unanimously.

Waiver of 24 Month ACGME/AOA Approved Post-Graduate Training

Jeffrey Rosenbaum, Medicine and Surgery (DO) Applicant

MOTION: Sumeet Goel moved, seconded by Gregory Schmeling, to approve the request for waiver of the 24 months of ACGME/AOA approved post-graduate training for Jeffrey Rosenbaum. Motion carried unanimously.

RECONVENE TO OPEN SESSION

MOTION: Michael Parish moved, seconded by Clarence Chou, to reconvene to Open Session. Motion carried unanimously.

The Board reconvened to Open Session at 12:51 p.m.

VOTE ON ITEMS CONSIDERED OR DELIBERATED UPON IN CLOSED SESSION

MOTION: Milton Bond moved, seconded by Emily Yu, to affirm all motions made and votes taken in Closed Session. Motion carried unanimously.

(Be advised that any recusals or abstentions reflected in the closed session motions stand for the purposes of the affirmation vote.)

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

MOTION: Michael Parish moved, seconded by Milton Bond, to delegate ratification of examination results to DSPS staff and to ratify all licenses and certificates as issued. Motion carried unanimously.

ADJOURNMENT

MOTION: Gregory Schmeling moved, seconded by Sumeet Goel, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 12:55 p.m.

State of Wisconsin
Department of Safety & Professional Services

AGENDA REQUEST FORM

1) Name and title of person submitting the request: Tom Ryan, Executive Director on behalf of Sheldon Wasserman, Chairperson		2) Date when request submitted: April 20, 2022 Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting
3) Name of Board, Committee, Council, Sections: Medical Examining Board		
4) Meeting Date: 5/4/2022	5) Attachments: ☐ Yes ☒ No	6) How should the item be titled on the agenda page? Professional Assistance Procedure (PAP) Discussion
7) Place Item in: ☒ Open Session ☐ Closed Session	8) Is an appearance before the Board being scheduled? ☒ Yes: Adam Wagner, Monitor ☐ No	9) Name of Case Advisor(s), if applicable: N/A

10) Describe the issue and action that should be addressed:

Adam Wagner from DLSC will appear provide a presentation about, and to discuss the Professional Assistance Procedure.

For reference:

- The Lorna Breen Heroes Foundation website: https://drlornabreen.org/
- The Federation of Physician Health Programs website: https://www.fsphp.org/
- FSMB Report and Recommendations of the Workgroup on Physician Wellness and Burnout: https://www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf
- FSMB Policy on Physician Illness and Impairment: Towards a Model that Optimizes Patient Safety and Physician Health: https://www.fsmb.org/siteassets/advocacy/policies/policy-on-physician-impairment.pdf

11) Authorization

Signature of person making this request	Date
Supervisor (Only required for post agenda deadline items)	Date
Executive Director signature (Indicates approval for post agenda deadline items)	Date

Directions for including supporting documents:
1. This form should be saved with any other documents submitted to the Agenda Items folders.
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.

WISCONSIN PROFESSIONAL ASSISTANCE PROCEDURE

Adam Wagner

Professional Assistance Procedure Coordinator

adam.wagner@wisconsin.gov

608-287-3753

Professional Assistance Procedure (PAP) Program Overview

The PAP program is a self-report, non-disciplinary, confidential program that is available to any individual who has been issued a professional credential by the Department or licensing board. The program's intent is to protect the public from credential holders who are impaired by reason of the abuse of alcohol or other drugs by promoting early identification of chemically dependent professionals and encouraging rehabilitation. The PAP agreement is for five years and includes AODA therapy, drug monitoring and AA/NA meetings as part of the agreement.

Authority

The PAP is regulated by Wisconsin Administrative Code Chapter SPS 7. This chapter outlines the program's intent along with the authority the department is given to operate the program.

Program Definitions (Full definitions SPS 7.02)

1. Board Liaison- The Board member designated by the Board or the Secretary/Secretary's designee as responsible for approving credential holders for PAP and for performing other responsibilities delegated to the Board liaison under these rules.

2. Coordinator- Department employee who coordinates PAP.

3. Board- Any Board, examining Board or affiliated credentialing Board attached to the Department.

4. Eligibility- Shall be determined by the Board liaison and coordinator who shall review all relevant materials. The decision on eligibility shall be consistent with the purposes of these procedures as described in SPS 7.01(2).

How does a licensee apply for the PAP?

- A licensee can apply for PAP by the following:
  - Self-report
  - Employer referral
  - Department Referral

Self-report- A licensee contacts the PAP program to report a chemical dependency directly.

Employer Referral- An employer has determined a licensee may need assistance and suggests/requires, as a condition of employment, to apply for PAP.

Department Referral- A licensee is being investigated for a complaint that was reported to the Department. The prosecuting attorney or case advisor (member of the Board) may recommend the licensee be referred to PAP.

Application Process

The licensee must submit a complete application along with the release of information form and AODA assessment(completed within previous six months). The licensee should provide as much detailed information regarding the specific incident(s) that led to the PAP application. Failure to provide truthful and accurate information may be grounds for denial into the program as described in SPS 7.05(1)(a).

Once the application and AODA assessment is received, the application materials are reviewed by the PAP coordinator. If any additional information is needed the coordinator will follow up. The coordinator will then send all related application information to the PAP liaison for a decision on eligibility.

If the licensee's application is approved, an agreement (contract) will be drafted for the licensee to sign.

If the Licensee's application is denied, his/her PAP application may be submitted for further investigation in accordance with SPS 7.03(6).

PAP Agreement

The PAP agreement is drafted by the coordinator after the licensee has been accepted into the program. The liaison will approve any practice limitations that are determined to be needed for the licensee. Once the agreement is completed, it will be reviewed by the PAP supervisor prior to presenting it to the licensee.

Once the licensee has received the agreement, he/she has 15 days to return a signed copy to the coordinator. If the licensee does not return a signed copy within the allotted time frame, the application may be deemed abandoned and referred to intake for a potential investigation.

The agreement becomes official once all parties have signed the agreement.

Most Common Terms and Conditions in a PAP Agreement:

- AODA therapy session twice per month.
- AA/NA meetings at a minimum of twice per week. The licensee is required to attend more if his/her AODA therapist recommends more.
- Drug monitoring which normally includes a minimum of 48 urine screens per year for the first year. Additional tests can/may be added as needed.
- Quarterly self-reports, AA/NA log, work supervisor reports and AODA treatment reports. All reports are provided by the Department.
- Practice limitations:
  - Direct supervision
  - No access to controlled substances (if applicable).
  - Practice setting restrictions such as inability to work in home health, pool, agency, assisted living, school or correctional setting.
  - Work under direct supervision:
    - The liaison will approve up to three staff individuals that have the same license as the licensee. One of those approved individuals needs to be on site anytime the licensee is working.
  - Abstain from all personal use of alcohol and only use prescribed medication. All RX's need to be sent to coordinator within 24 hours of ingestion.

Most Common Terms and Conditions in a PAP Agreement (continued):

Licensee can request modifications to the agreement on an annual basis. Modifications to the agreement are based on the licensee's overall compliance. Examples of modifications include:

- Reduction in drug monitoring screens.
- Reduction in AODA therapy.
- Reduction in AA/NA meetings.
- Practice limitation modifications.

The PAP intent is to promote full compliance with all terms and conditions of the agreement. Failure to comply can have an impact on future modification requests and may extend the agreement past the 5-year period.

If the licensee cannot comply or has multiple relapses, he/she will be discharged from the PAP program and may be referred to intake for a potential investigation.

Drug Monitoring Program

PAP participants must enroll with Vault (formerly First Source Solutions) for the drug testing component. Program rules have been established by the Department. Each licensee will be required to follow the program rules and industry standards. Tests are scheduled randomly by Vault based on requirements set forth in the agreement.

Program rules:

- Check in daily (via phone, internet or mobile app).
- If selected, provide the specimen with-in 5 hours of notification.
- Required to check-in/test on weekends, holidays and vacations

A licensee is allowed to travel at any time and to any destination. However, the licensee is still required to check in daily and provide a specimen if he/she is selected. Currently, Vault does not offer testing outside of the United States. If a licensee travels outside of the United States, any missed tests/check-ins will be unexcused and may affect his/her eligibility in the program, as well as any future modification requests.

Drug testing program rules are not eligible to be modified. Rules are the same for each licensee and remain the same until the licensee is discharged from the program (exception: reduction in screens on an annual basis if approved by the liaison).

What to Expect From the Program:

Once the participant has been provided notification the agreement has been approved, participants can expect routine contact with the coordinator. Communication is a big part of the program.

The program is not a treatment facility/provider. Rather, it is a program designed to give a participant an opportunity to seek the help needed to maintain his/her professional license in good standing.

Participant ALWAYS has the option to seek and retain legal counsel at anytime during the process.

Coordinator will aid in communicating with potential employers regarding any specific questions they may have about the participant's practice limitations. Coordinator will also help obtain the information and position description needed for the approval process.

What to Expect From the Program (continued):

A few setbacks are common/expected throughout the contract period for each participant. In most cases a solution can be found. In rare cases, a participant may be discharged from the program and referred for a potential investigation.

Once a participant reaches the 5-year eligibility date, he/she must submit a request to be discharged. If the discharge is approved, the participant will be notified via email (letter on Department letterhead will be attached) of successful completion.

Frequently Asked Questions;

- Is it possible to be discharged from my PAP agreement early? No. You will be required to participate for 5 years. The PAP liaison must grant a discharge after successful completion.
- Can I be enrolled in another state's program and still be considered in compliance without having to test for both programs? Yes. The program works in conjunction with other states to avoid having the participant test for both programs. The primary state would be where the licensee works, with the other state receiving compliance reports and notifications of violations in a timely manner.
- What if I work 12-hour shifts on a rotating basis and cannot test? Unfortunately, you will still be required to test. This may be a deciding factor in participating or not. The alternative is having a Board issued Order requiring the same drug testing requirement.
- Can I find employment with the practice limitations? Yes. A significant number of nurses can find employment with these practice limitations.
- Does the PAP program have a cost for participation? Yes. The licensee is responsible for the cost of AODA therapy, drug testing, and collection costs. The licensee does not pay a fee to the Department.
- Can a licensee communicate directly with the liaison? No. The coordinator will relay all communication/information to the liaison.
- Does a licensee have the ability to appeal a denial? Yes. SPS 7.03 (7) states that within 10 days of the denial letter a licensee can request to have the Credentialing authority review the adverse determination.

Questions?

The Federation of State Physician Health Programs

https://www.fsphp.org/

About FSPHP

The Federation of State Physician Health Programs, Inc. (FSPHP) is a national membership association of Physician and Health Professional Programs (PHPs). FSPHP is a 501c3 nonprofit established in 1991, that evolved from initiatives taken by the American Medical Association (AMA), the Federation of State Medical Boards (FSMB), State Medical Societies/Associations and individual state physician health programs. Our member programs provide confidential assessment, referral to treatment, resources and monitoring for physicians/healthcare professionals, and those in training who may be at risk of impairment from mental illness, substance use disorders and other health conditions. When indicated, ongoing health monitoring by a PHP provides trusted accountability that supports successful continuation or return to practice. Most importantly, state member programs provide a confidential, therapeutic alternative to discipline and have the support of organized medicine in their state or province often through legislation, exceptions to mandated reporting, or other safe haven provisions. In addition to working with participants, PHPs provide education, outreach, and advocacy to their medical communities in support of physician health and well-being.

State Programs: https://www.fsphp.org/state-programs

A few website pages you may find valuable:

- FSPHP hallmark annual education event
- State PHP directory
- Valuable resources on physician health

Mission, Vision and Values

Mission: To support physician health programs in improving the health of medical professionals, thereby contributing to quality patient care.
Vision: A society of highly effective PHPs advancing the health of the medical community and the patients they serve.

Physician Wellness and Burnout

Report and Recommendations of the Workgroup on Physician Wellness and Burnout

Adopted as policy by the Federation of State Medical Boards
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Executive Summary:

The Federation of State Medical Boards (FSMB) Workgroup on Physician Wellness and Burnout was convened in April of 2016 by FSMB Chair Arthur S. Hengerer, M.D. to identify resources and strategies to address physician burnout.

While the Workgroup examined the issue of physician burnout from a broad perspective, reviewing as many facets of this complex issue as possible, including existing research, resources, and strategies for addressing it, the recommendations for state medical and osteopathic boards (hereinafter referred to collectively as "state medical boards") found in this report focus first and foremost on the licensing process. The Workgroup also saw fit to include commentary and recommendations on several other aspects of physician wellness and burnout, though some of these areas may not be under the direct purview of the FSMB or its member boards. The FSMB recognizes the importance of collaboration for effectively supporting physicians and protecting patients in the face of circumstances that lead to burnout, which is ultimately a patient safety issue. A shared accountability model that includes responsibilities to be carried out by providers from all the health professions, including physicians and physician assistants, and with organizations from across the health care community is therefore recommended as the most promising course of action to address this important issue.

Recommendations for state medical boards related to the licensing process include considering whether it is necessary to include probing questions about a physician applicant's mental health, addiction, or substance use on applications for medical licensure or their renewal, and whether the information these questions are designed to elicit, ostensibly in the interests of patient safety, may be better obtained through means less likely to discourage treatment-seeking among physician applicants.

Where member boards strongly feel that questions addressing the mental health of physician applicants must be included on medical licensing applications, several recommendations are included in this report for the appropriate phrasing of such questions, including focusing only on current impairment, which may be more meaningful in the context of a physician's ability to provide safe care to patients in the immediate future.

State medical boards are also encouraged to approach physician wellness and burnout from a non-punitive perspective, avoiding public disclosure of any information about a physician's diagnosis during licensing processes and offering "safe haven" non-reporting

options (mentioned later in this report) to physicians who are under treatment and in good standing with a recognized physician health program (PHP) or other appropriate care provider.

It is also recommended that boards take advantage of all opportunities available to them to discuss physician wellness, communicate regularly with licensees about relevant board policies and available resources, and make meaningful contributions to the ongoing national dialogue about burnout in order to advance a positive cultural change that reduces the stigma among and about physicians seeking treatment for mental, behavioral, physical or other medical needs of their own.

The Workgroup's recommendations to external organizations and stakeholders focus on increasing the awareness and availability of information and resources for addressing physician burnout and improving wellness. The value of noting and listing the availability of accessible, private, confidential counselling resources is a particular point of emphasis in this report, as is dedicating efforts to ensuring that any new regulation, technology, or initiative is implemented with due consideration to any potential for negative impact on physician wellness.

This report, which follows two years of careful study, evaluation and discussion by Workgroup members, FSMB staff, and various stakeholders, is intended to support initial steps by the medical regulatory community to begin to address the issues associated with promotion of physician wellness and mitigation of burnout, to the extent that is possible. The information and recommendations contained herein are based on principles of fairness and transparency, and grounded in the primacy of patient safety. They emphasize a responsibility among state medical boards to work to ensure physician wellness as a component of their statutory right and duty to protect patients.

Background and Charge:

In 2014, the Ethics and Professionalism Committee of the Federation of State Medical Boards (FSMB) engaged in several discussions about the risks to patient safety that may result from disruptive physician behavior. As these discussions proceeded, it became apparent from a review of the literature and discussions with state medical boards that a link exists between many instances of disruptive behavior and symptoms of professional burnout experienced by so-called "disruptive physicians." The Committee, chaired by Dr. Janelle A. Rhyne, M.D., MACP, determined that further research into physician health, self-care, and burnout should be conducted to identify resources that may be of value for state medical boards and physicians alike, and to outline possible roles for the FSMB and its partners to better promote patient safety and quality health care.

Given the complexity of the issue and the many factors contributing to physician burnout, in 2016, Dr. Arthur S. Hengerer, MD, (while serving as Chair of the FSMB), established the FSMB Workgroup on Physician Wellness and Burnout to study the issue further. The Workgroup was specifically charged with identifying resources and strategies to address

physician burnout. To accomplish its charge, the Workgroup reported that it would engage in a multi-part work program that would likely involve: 1) educating state medical boards and physicians through the creation of a compendium of research and resources on identifying, managing and preventing physician burnout; 2) raising awareness about the prevalence of burnout among physicians and other health care professionals, helping reduce the stigma sometimes associated with physicians seeking help for burnout symptoms; 3) evaluating current research on the impact of physician burnout on patient care; and 4) convening stakeholder organizations and experts to discuss physician wellness and to recommend best practices for promoting physician wellness and helping physicians identify, manage and prevent burnout throughout their career continuum (i.e. from medical school through residency training and throughout their years of licensed, unsupervised practice.)

The purpose of this report is to summarize the steps taken by the Workgroup in fulfilment of their charge, to share information gathered as part of this process, and to provide a series of recommendations for state medical boards and others to consider for addressing burnout and its symptoms. It should be noted that the Workgroup's charge does not include tasks related to defining the phenomenon of burnout or performing further analysis into the concept itself, as it was felt there is a significant amount of valuable research that has already been done in these areas and is ongoing. Much of this research, including some that is inchoate, was reviewed by the Workgroup in fulfilment of the third component of its charge. This body of research is referenced herein and informs many of the recommendations contained in this report. While burnout is a phenomenon that may impact physicians at all stages of their career, it should be noted that the recommendations specific to state medical boards in this report focus primarily on the licensing process. The Workgroup feels it is also important, however, to share information in this report related to issues beyond the licensing process. Such additional information and guidance is provided for the benefit of relevant partner organizations and stakeholders responsible for undergraduate, graduate and continuing medical education; medical school, residency training and health facility accreditation; governance, information technology, health insurance, and other activities and functions that support the provision of health care to the nation's citizens.

In developing the content and recommendations of this report, the Workgroup understands and endorses the importance of the "quadruple aim," which added a call for improvements in the quality of work lives of physicians and other health care providers[1] to the existing three aims of improving the health of populations, enhancing the patient experience of care, and reducing the per capita cost of health care.[2] As argued by proponents of the fourth aim, improved population health cannot be achieved without ensuring the health and well-being of health care providers.

[1] Bodenheimer T, Sinsky C (2014), From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. *Ann Fam Med*, 12 (6): 573-576.
[2] Berwick DM, Nolan TW, Whittington J. (2008). The Triple Aim: care, health, and cost. *Health Aff* (Millwood), 27(3):759–69.

Several definitions have been applied to the phenomenon of physician burnout and, for the purposes of this report, it is considered a psychological response that may be experienced by doctors exposed to chronic situational stressors in the health care practice environment. This is characterized by overwhelming exhaustion, feelings of cynicism and detachment from work, and a sense of ineffectiveness and lack of accomplishment.[3] While burnout's manifestations and consequences vary widely, they could result in significant harm to patients.

It has been widely reported for more than a decade that nearly 100,000 preventable medical errors occur in the United States each year.[4] More recent findings suggest that between 210,000 and 400,000 deaths each year are associated with preventable harm.[5] Many of these errors may be attributed to physician burnout and its drivers, such as excessive caseloads, negative workplace culture, poor work-life balance, or perceived lack of autonomy in one's work.[6] Burnout affects a significant proportion of the U.S. physician workforce. A 2012 study conducted by Shanafelt and colleagues showed that 45.5% of surveyed physicians demonstrated at least one symptom of burnout.[7] When this study was repeated three years later with a different sample, the authors demonstrated that burnout and work-life dissatisfaction had increased by 9% over the three year period.[8] In addition to obvious risks to patient safety, an alarming and extreme result of physician burnout has been the disproportionate (relative to the general population) levels of suicide in recent years by physicians, medical residents and even medical students.[9,10] One is hard-pressed to find a phenomenon that negatively affects a broader array of stakeholders in health care than burnout. It impacts providers from all health professions. State medical boards' duty to protect the public, in this regard, also includes a responsibility to ensure the wellness of its licensees.

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[3] Maslach, C., Jackson, S.E. (1981). The Measurement of Experienced Burnout. *Journal of Occupational Behavior*, 2(2):99-113. See also, Maslach C, Jackson SE, Leiter MP. *(*1996). *Maslach Burnout Inventory Manual. 3rd ed*. and Maslach C, et al. (2001). Job Burnout. *Annu Rev Psychol*, 52:397–422.

[4] Kohn LT, Corrigan J, Donaldson MS. (2000). To Err Is Human: Building a Safer Health System. Washington, DC: National Academies Press (US).

[5] James JT. (2013). A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care. *Journal of Patient Safety***,** 9(3):122-128.

[6] Shanafelt TD, Noseworthy JH. (2016). Executive leadership and physician well-being: Nine organizational strategies to promote engagement and reduce burnout. *Mayo Clin Proc*, 92:129-146.

[7] Shanafelt TD, et al. (2012). Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Archives of Internal Medicine*, 172(18):1377-1385.

[8] Shanafelt TD, Hasan O, Dyrbye L, et al. (2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clin Proc,* 90:1600-1613.

[9] Rubin R. (2014). Recent Suicides Highlight Need to Address Depression in Medical Students and Residents. *JAMA,* 312(17):1725-1727.

[10] Gold KJ, Sen A, Schwenk TL. (2013). Details on suicide among US physicians: data from the National Violent Death Reporting System. *Gen Hosp Psych,* 35:45-49.

Features and Consequences of Burnout:

Physicians experiencing burnout, according to the medical literature, exhibit a wide array of signs, symptoms and related conditions, including fatigue, loss of empathy, detachment, depression, and suicidal ideation. The three principal components of burnout are widely described in the medical literature as emotional exhaustion, depersonalization, and diminished feelings of personal accomplishment.[11] Many of these symptoms are also said to be linked to low levels of career satisfaction.

Career satisfaction may be diminished by even a single influencing factor. Unreasonable increases in workload, for example, may quickly lead to dissatisfaction with one's career. Loss of job satisfaction has been noted as both a primary contributor to burnout as well as a contributor to its further progression.[12] Burnout has specifically been found to be the single greatest predictor of surgeons' satisfaction with career and choice of specialty.[13] It may also be a significant contributor to increased rates of suicidal ideation among both physicians[14] and medical students.[15]

Physicians experiencing manifestations of burnout are also reported to be more prone to engage in unprofessional behavior,[16] commit surgical or diagnostic medical errors,[17,18,19] and lose the trust[20] of their patients, while also decreasing their satisfaction.[21] At a time when there is compelling evidence of a shortage of qualified practicing physicians in many parts of the United States, losing additional physicians to early or unnecessary retirement would have a detrimental impact on patient access to care across the country. As the American Medical Association's Policy on Physician Health and Wellness states,

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[11] Maslach C, Schaufeli WB, Leiter MP. (2001). Job burnout. *Annual Review of Psychology,* 52:397-422.
[12] Mirvis DM, Graney MJ, Kilpatrick AO. (1999). Burnout among leaders of the Department of Veterans Affairs medical centers: contributing factors as determined by a longitudinal study. *J Health Hum Serv Adm,* 21:390-412, and Mirvis DM, Graney MJ, Kilpatrick AO. (1999). Trends in burnout and related measures of organizational stress among leaders of Department of Veterans Affairs medical centers. *J Healthc Manag*, 44(5):353-365. (Via Chopra SS. (2004). JAMA, 291(5):633).

[13] Shanafelt TD, et al. (2009). Burnout and Career Satisfaction among American Surgeons. *Annals of Surgery*, 250(3):463-471.
[14] Shanafelt TD, Balch CM, Dyrbye LN, et al. (2011). Suicidal ideation among American surgeons. *Arch Surg*, 146:54-62.
[15] Schwenk TL, Davis L, Wimsatt LA. (2010). Depression, stigma, and suicidal ideation in medical students. *JAMA*, 304(11): 1181-1190.
[16] Dyrbye LN, Massie FS, Jr., Eacker A, et al. (2010). Relationship between burnout and professional conduct and attitudes among US medical students. *JAMA,* 304: 1173-1180.
[17] Privitera MR, et al. (2015). Physician Burnout and Occupational Stress: An inconvenient truth with unintended consequences. *Journal of Hospital Administration*, 4(1).
[18] Shanafelt TD, Balch CM, Bechamps G, et al. (2010). Burnout and medical errors among American surgeons. *Ann Surg,* 251:995-1000.
[19] West CP, Huschka MM, Novotny PJ, et al. (2006). Association of perceived medical errors with resident distress and empathy: a prospective longitudinal study. *JAMA*, 296(9):1071-1078.
[20] Haas JS, Cook EF, Puopolo AL, Burstin HR, Cleary PD, Brennan TA. (2000). Is the professional satisfaction of general internists associated with patient satisfaction? *J Gen Intern Med*, 15(2):122-128.
[21] Anagnostopolous F, Liolios E, Persefonis G, Slater J, Kefetsios K, Niakas D. (2012). Physician burnout and patient satisfaction with consultation in primary health care settings: evidence of relationships from a one-with-many design. *J Clin Psychol Med Settings*. 19(4):401-410.

"When health or wellness is compromised, so may be the safety and effectiveness of the medical care provided."[22]

Factors Contributing to Burnout:

While a large proportion of physicians are said to experience burnout and its correlates, they do not always experience it in the same way or for the same reasons. Physicians may be predisposed to burnout because of personality traits that led them to pursue a medical career in the first place, such as perfectionism, self-denial, and compulsiveness. These are traits that are said to be common among practicing physicians. Predisposition to burnout may be stronger in instances where personal factors such as denial of personal vulnerability, tendencies to delay gratification, or excess feelings of guilt are layered onto these aforementioned personality traits. While burnout is a distinct phenomenon from mental illness and substance use disorders, the latter two issues can play a compounding role in a physician's struggle with burnout, making the identification and effective treatment of its symptoms or causes even more difficult.[23]

It is a common misconception that physicians are more susceptible to suffering from burnout at later stages in their career, presumably from fatigue and aging. In fact, research has demonstrated that physicians in the middle of their careers are at the highest risk for burnout.[24] Education and training also appear to be critical peak times for physicians, physicians-in-training or medical students to suffer from burnout.[25,26]

The environment in which physicians work, including their choice of specialty, also plays a significant role in contributing to burnout. Shanafelt and colleagues have shown substantial differences in burnout rates by specialty, although changes in the highest and lowest rates were noted between 2011[27] and 2014.[28] The control, or lack thereof, that physicians have over their work environment plays a significant role in predisposition to burnout. This may explain why emergency medicine is frequently found at or near the top of the list of medical and surgical specialties with the highest proportion of physicians experiencing burnout. Emergency physicians often work in environments that are high-demand and low-control.[29] While finding meaning in one's work has long been claimed

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[22] *Code of Medical Ethics*, (2016). American Medical Association, Opinion 9.3.1.
[23] Oreskovich M, Kaups K, Balch C, et al. (2011). The prevalence of alcohol use disorders among American surgeons. *Arch Surg*, 147:168-174.
[24] Dyrbye LN, et al. (2013). Physician satisfaction and burnout at different career stages. *Mayo Clinic Proceedings*, 88(12):1358-1367.
[25] Dyrbye LN, Shanafelt TD. (2016). A narrative review on burnout experienced by medical students and residents. Med Educ, 50:132-149.
[26] Dyrbye LN, et al. (2014). Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. *Academic Medicine*, 89(3):443-451.
[27] Shanafelt TD, et al. (2012). Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Archives of Internal Medicine,* 172(18):1377-1385.
[28] Shanafelt TD, Hasan O, Dyrbye L, et al. (2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clin Proc,* 90:1600-1613.
[29] https://www.medpagetoday.com/emergencymedicine/emergencymedicine/54916

to be the antidote to burnout,[30] it may be difficult to find such meaning absent an adequate degree of control over one's work environment.

The movement towards maximal standardization of processes, often labeled a phenomenon of "deprofessionalization," is also claimed to be a contributor to burnout among physicians. There is worry among some professionals, in medicine and other health care fields, that an expectation for rigid adherence to guidelines will replace what were formerly considered the more elegant, artistic and satisfying aspects of medical practice.[31] These movements need not be perceived as threats to physician autonomy or to the exercise of professional judgment. Rather, embracing evidence-based medicine, focusing on the value of care that is provided, and celebrating increasingly positive outcomes can contribute to great improvements in patient and population health. Professional judgment will continue to play an important role in realizing these improvements.

Frustrations have also been voiced in relation to the move in health care delivery away from paper-based records to electronic health records (EHRs). Many physicians have expressed dissatisfaction with the intrusiveness and complexity of EHR use and the limits this sometimes places on the ways in which they are able and capable of effectively documenting treatment decisions and provision of care.[32] These frustrations exist in addition to those related to the often complex, redundant, or non-intuitive methods of data entry and other elements of medical record keeping associated with EHRs,[33,34,35] as well as the fact that most systems are not yet fully interoperable. However, complaints made about particular aspects of an evolving or disruptive technology should not be interpreted as calls to abandon the important gains in patient safety, professional communication, and even efficiency that have been brought about by the introduction and implementation of EHR systems. Rather, they should be interpreted as important user feedback that may contribute to ongoing improvement of such technology.

The constantly changing and evolving nature of medicine, as well as the challenges faced by the American health care system itself, also appear to be affecting the way many physicians feel within their professional roles. A recent study reported that 65% of physicians who were surveyed predicted an ongoing deterioration in the quality of health care that they deliver, which in turn has been attributed, in part, to the erosion of

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[30] Sotile W. (2002). *The Resilient Physician*.
[31] Aasland OG. (2015). Healthy Doctors – Sick Medicine. *Professions and Professionalism*, 5(1).
[32] Friedberg MW, et al. (2013). Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy. RAND Corporation, https://www.rand.org/pubs/research_reports/RR439.html.
[33] Arndt BG, et al. (2017). Tethered to the EHR: Primary Care Physician Workload Assessment Using EHR Event Log Data and Time-Motion Observations. *Ann Fam Med*, 15(5):419-426.
[34] Levinson J, Price BH, Saini V. (2017). Death By A Thousand Clicks: Leading Boston Doctors Decry Electronic Medical Records. Common Health, http://www.wbur.org/commonhealth/2017/05/12/boston-electronic-medical-records.
[35] Sinsky C, et al. (2016) Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. *Ann Intern Med*. 165:753-760.

physician autonomy.[36] When evolving requirements are layered onto new expectations with regard to technology, quality reporting, increased clinical volume, and numerous other initiatives required by payers, employers, and even state medical boards, it may not be surprising that physicians are experiencing burnout at alarming rates. While many of the initiatives that place additional burdens on physicians are grounded in strong rationales related to patient safety and quality care, the burnout resulting from their combined effect may actually inhibit the success of the initiatives themselves.[37] This should certainly bring pause to those charged with implementing initiatives and requirements to carefully evaluate their effectiveness, unintended consequences, and potential burden, but also to communicate their goals and perceived value. The reaction of the profession to the ongoing changes that are occurring may also indicate particular attitudes within the culture of medicine that would benefit from further discussion, as would support to integrate positive change into practice.

Burnout is not always related to stressors arising in a physician's work environment or to a physician's character traits. Family issues, personal and professional relationships, financial pressures, insufficient work-life balance, or other external stressors may also contribute to burnout. Efforts aimed at the identification, treatment, or prevention of burnout must, therefore, approach the issue from a broad enough perspective to take all of these factors into account.

Challenges and Barriers to Addressing Burnout:

While there has been a promising rise in the number of peer-reviewed research publications addressing the topic of physician burnout, in the academic medical literature, popular media and so-called gray literature (e.g., white papers, position statements, organizational reports), there seems to be a perceived lack of resources available to identify and address the issue. This perception may be misguided, however, since several academic institutions, health systems, medical specialty societies, independent physicians, physician health programs, and state medical boards make many useful, high-quality resources available (See Appendix A.). While more resources would be beneficial to physicians, and ultimately their patients, their development should be complemented with efforts aimed at highlighting best practices. Research is also needed to identify how sources of burnout might differ for male and female physicians in order that resources may be appropriately tailored. A more coordinated effort to raise awareness not only about the issue of physician burnout but also about resources for ameliorating related circumstances may also serve to reduce stigma and facilitate identification and treatment. It may also help improve systems issues that impact burnout by improving communication, team building, and collaboration within and among health care

[36] Emanuel EJ, Pearson SD. (2012). Physician autonomy and health care reform. *Journal of the American Medical Association*, *307*(4), 367-368.
[37] Dyrbye LN, Shanafelt TD. (2011). Physician Burnout: A Potential Threat to Successful Health Care Reform. *JAMA 305(19):2009-2010*.

professions. Broader awareness may also better equip physicians in their capacity as leaders to improve circumstances for those with whom they work.[38]

Many physicians are reluctant to seek help for burnout or any of its many underlying causes for fear that they will be perceived as weak or unfit to practice medicine by their colleagues or employers, or because they assume that seeking such care may have a detrimental effect on their ability to renew or retain their state medical license, arguably the most important credential a physician receives during their professional career.[39,40,41,42,43] This stigma may be felt as early as medical school,[44] a particularly dangerous cultural feature in a population where symptoms of anxiety and depression have been found to be more prevalent than in the general population.[45] In a study by Dyrbye and colleagues, it was found that only a third of the medical students experiencing features of burnout sought help and that stigma was seen as a barrier for those who chose not to seek help.[46] The same reluctance is seen with respect to help-seeking for other types of stigmatized suffering such as depression, substance use disorders, or suicidal ideation.[47] Without adequate modeling of appropriate self-care behaviors among faculty mentors, progress at stigma reduction will likely be slow. Further, while there are laudable examples of programs at academic medical centers across the country which responsibly offer accessible, complementary, private, and confidential counselling to medical students,[48] these programs are by no means widely available.

Privacy and confidentiality of a physician's health and treatment history is important to allow those in need of help to come forward without fear of punishment, disciplinary

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[38] Shanafelt TD, et al. (2015). Impact of Organizational Leadership on Physician Burnout and Satisfaction, *Mayo Clinic Proceedings*, 90(4):432-440.
[39] Chew-Graham CA, et al. (2003). 'I wouldn't want it on my CV or their records': medical students' experiences of help-seeking for mental health problems. *Medical Education*, 37(10):873–880.
[40] Federation of State Medical Boards. (2011). Policy on Physician Impairment.
[41] Guille C, et al. (2010). Utilization and Barriers to Mental Health Services Among Depressed Medical Interns: A Prospective Multisite Study, *Journal of Graduate Medical Education*, 2(2):210-214.
[42] Gold K, et al. (2016). "I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting. *General Hospital Psychiatry,* 43:51–57.
[43] Dyrbye LN, et al. (2017). Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions. *Mayo Clin Proc*, 92(10):1486-1493.
[44] Schwenk TL, et al. (2010). Depression, Stigma, and Suicidal Ideation in Medical Students. *JAMA,* 304(11):1181-1190.
[45] Rotenstein LS, Ramos MA, Torre M, et al. (2016). Prevalence of depression, depressive symptoms, and suicidal ideation among medical students, a systematic review and meta-analysis. *JAMA,* 316(21):2214-2236.
[46] Dyrbye LN, et al. (2015). The Impact of Stigma and Personal Experiences on the Help-Seeking Behaviors of Medical Students with Burnout. *Academic Medicine*, 90(7):961-969.
[47] Dyrbye LN, et al. (2017). Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions. *Mayo Clin Proc*, 92(10):1486-1493.
[48] Examples include the HEAR Program at UC San Diego (available to everyone at the UCSD Health System, not only medical students), the Henderson Student Counseling Center at Nova Southeastern University, the Wellness Resources offered at Oregon Health and Science University, and the Medical Student Counseling and Wellness Center at the Herbert Wertheim College of Medicine, Florida International University.

action, embarrassment or professional isolation. The use of confidential services whenever possible in lieu of regulatory awareness is preferred in order to mitigate fear of negative impacts on licensure, employment, or collegial relationships. When confidential services are not utilized, it is less likely licensees will receive early intervention and appropriate treatment, thereby foregoing opportunities for early detection of potentially impairing illness or recovery.

Funding for important programs and initiatives such as those identified above is often difficult to obtain. However, there is a growing body of research that identifies the cost savings for hospitals and employers associated with providing them, particularly when costs associated with medical errors and lower quality of care attributed to burnout are mitigated, as are high turnover rates, absenteeism, and loss of productivity.[49]

Another challenge to identifying and addressing burnout is the fact that the associated stigma may reduce the degree to which the phenomenon itself is discussed. This impacts not only a physician's own willingness to discuss or seek help for burnout, but also the willingness of fellow physicians to address or report instances of impairment among their colleagues, especially that which unduly risks the safety of patients. While the duty to report impairment or incompetence and the duty to encourage help-seeking may seem to conflict, in that a fear of being reported could cause a physician to conceal problems and avoid help, the duty to report is actually based on principles of patient safety and ethics. The duty to report also aims to assist physicians in seeking the help they need in order to continue practicing safely.

In addition to the cultural stigma associated with admitting experiences of burnout, recent research has shed light on the potential impact of licensure and license renewal processes of state medical boards that may discourage treatment-seeking among physicians.[50,51] State medical boards may inadvertently discriminate unfairly against physicians suffering from mental illness or substance use disorders, or against those who choose to take a leave of absence from practice to prevent or recover from burnout. The very presence of application questions for medical licensure or licensure renewal may stigmatize those suffering from mental and behavioral illnesses for which physicians might otherwise seek care. In fact, questions about substance abuse and mental illness on state medical licensure renewal applications have nearly doubled between 1996 and 2006.[52] While information about a physician's health status (both mental and physical) may be essential to a state medical board's solemn duty to protect the public, the FSMB has previously noted that a history of mental illness or substance use does not reliably predict future risk

[49] Shanafelt T, Goh G, Sinsky C. (2017). The Business Case for Investing in Physician Well-Being. *JAMA Intern Med*. 177(12):1826-1832.
[50] Gold K, et al. (2016). "I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting. *General Hospital Psychiatry,* 43:51–57.
[51] Dyrbye LN, et al. (2017). Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions. *Mayo Clin Proc*, 92(10):1486-1493.
[52] Polfliet SJ. (2008). A National Analysis of Medical Licensure Applications. *J Am Acad Psychiatry Law*, 36(3): 372.

to the public.[53] It is also very important to recognize that court interpretations of the Americans with Disabilities Act (ADA) have suggested that state medical boards should focus on current functional impairment rather than a history of diagnoses or treatment of such illness.[54]

In carrying out their duty to protect the public and ensure that only individuals who are fully qualified to practice medicine are granted licenses, state medical boards usually, and for good reasons, insist that they must have sufficient information with which to make medical licensure decisions. During the licensure granting process, state boards also work diligently to ensure that candidates for licensure (or renewal) provide a thorough assessment of their fitness to practice, balanced by protecting their rights as contained in ADA legislation. Fear among prospective and current licensees about potential limitations placed on their ability to practice medicine independently, however, or of their previous diagnoses or treatments somehow being made public despite HIPAA and other federal privacy and confidentiality laws, may cause some physicians to misrepresent personal information that is requested or not respond accurately at all to licensing application questions.[55] In such instances, paradoxically, the efforts of state medical boards to get comprehensive information may not yield the accurate information they seek about a physician's practice risks to patients. They may also discourage treatment-seeking among physicians, thereby increasing the degree of risk to patients presented by physicians experiencing conditions that remain undiagnosed or untreated.

Recommendations:

The majority of the recommendations that follow are designed for state medical boards to consider and pertain mainly to the inclusion and phrasing of questions on state medical licensing applications. Appropriately addressing the issue of physician burnout provides a unique opportunity for state medical boards to declare, directly or indirectly, that it is not only normal but anticipated and acceptable for a physician to feel overwhelmed from time to time and to seek help when appropriate. This is also an important opportunity for state medical boards to highlight and promote the benefits of physician health, both mental and physical, to help reduce stigma, to clarify related regulatory and reporting issues, promote patient safety and assure the delivery of quality health care. Physicians should feel safe about reporting burnout and be able to take appropriate measures to address it without fear of having their licensure status placed in jeopardy.

Safeguarding physician wellness and mitigating damage caused by burnout cannot be accomplished through isolated actions and initiatives by individual organizations alone. Coordinated efforts and ongoing collaboration will be essential not only for addressing

[53] Federation of State Medical Boards. (2006). Federation of State Medical Boards: Americans With Disabilities Act of 1990. License Application Questions: A Handbook for Medical Boards.
[54] Polfliet SJ. (2008). A National Analysis of Medical Licensure Applications. *J Am Acad Psychiatry Law*, 36(3):373.
[55] Gold K, et al. (2016). "I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting. *General Hospital Psychiatry,* 43:51–57.

the many systemic issues that contribute to burnout but also for ensuring that appropriate tools, resources, and programs are continuously in place and readily available to help physicians avoid and address burnout. As such, the FSMB also offers suggestions and recommendations to its partner organizations, many of which have been instrumental in furthering the FSMB's current understanding of burnout, its related features, and the role of the regulatory community in addressing and safeguarding physician health.

Ultimately, the Workgroup and the FSMB believe that a shared accountability model that includes several related responsibilities among regulatory, educational, systemic, organizational, and administrative stakeholders provides a promising way forward. The specific recommendations outlined below begin to address what such responsibilities should entail.

The FSMB recognizes its responsibility to help address physician burnout, not only through following its own recommendations and promoting the resources provided in this report, but also by continuing its collaborative efforts with partner organizations from across the wider health care community.

For State Medical Boards:

1. The FSMB recommends that state medical boards review their medical licensure (and renewal) applications and **evaluate whether it is necessary to include probing questions about a physician applicant's mental health, addiction, or substance use**, and whether the information these questions are designed to elicit in the interests of patient safety may be obtained through means that are less likely to discourage treatment-seeking among physician applicants. For example, some boards subscribe to notification services such as the National Practitioner Data Bank's "Continuous Query" service or other data services that provide information about arrests or convictions, including for driving under the influence, within their states which can serve as a proxy finding for physician impairment. The FSMB also recommends in its *Essentials of a State Medical and Osteopathic Practice Act* that boards require applicants to satisfactorily pass a criminal background check as a condition of licensure.[56]

2. Where state medical boards strongly feel that questions addressing the mental health of physician applicants must be included on medical licensing applications, they should **carefully review their applications to ensure that appropriate differentiation is made between the illness with which a physician has been diagnosed and the impairments that may result**. Application questions must focus only on current impairment and not on illness, diagnosis, or previous treatment in order to be compliant with the Americans with Disabilities Act (ADA).

[56] Federation of State Medical Boards. (2015). *Essentials of a State Medical and Osteopathic Practice Act.*

3. The ADA requires licensure application questions to focus on the presence or absence of current impairments that are meaningful in the context of the physician's practice, competence, and ability to provide safe medical treatment to patients. **Applications must not seek information about impairment that may have occurred in the distant past and state medical boards should limit the time window for such historical questions to two years or less, though a focus on the presence or absence of current impairment is preferred.**

   Questions that address the mental health of the applicant should be posed in the same manner as questions about physical health, as there is no distinction between impairment that might result from physical and mental illness that would be meaningful in the context of the provision of safe treatment to patients.

   Where boards wish to retain questions about the health of applicants on licensing applications, **the FSMB recommends that they use the language:** ***Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?*** **(Yes/No)**[57,58]

4. **The FSMB recommends that state medical boards consider offering the option of "safe haven non-reporting" to applicants for licensure who are receiving appropriate treatment for mental health or addiction**. While it is up to boards to determine what constitutes appropriate treatment, the FSMB recommends that physicians who are monitored by, and in good standing with, the recommendations of a state or territorial Physician Health Program (PHP) be permitted to apply for medical licensure or license renewal without having to disclose their diagnosis or treatment to the board. The option of safe haven non-reporting should only be offered when treatment received is commensurate with the illness being treated and has a reasonable chance of avoiding any resultant impairment.

5. **State medical boards should work with their state legislatures to ensure that the personal health information of licensees related to an illness or diagnosis is not publicly disclosed as part of a board's processes**. Information disclosed must relate only to impairment of professional abilities, medical malpractice, and professional misconduct.[59]

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[57] American Psychiatric Association. (2015). Position statement on inquiries about diagnosis and treatment of mental disorders in connection with professional credentialing and licensing.
[58] The American Psychiatric Association (APA) passed an Action Paper in November 2017, resolving to query state medical boards and notify them about their compliance with APA policy and the ADA.
[59] Center C, Davis M, Detre T, et al. (2003). Confronting depression and suicide in physicians: a consensus statement. *JAMA*, 289(23):3161–3166.

6. **State medical boards should emphasize the importance of physician health, self-care, and treatment-seeking for all health conditions by including a statement to this effect on medical licensing applications, state board websites, and other official board communications**. Where appropriate, options for treatment and other resources should be made available, such as information about a state Physician Health Program (PHP), services offered through a county, state, or national medical society, and any other relevant programs. These means of communicating the importance of physician health and self-care are aimed at helping physicians with relevant information and resources but could also help raise awareness among patients of the importance of physician wellness and the threat of burnout to their doctors and their own care.

7. **State medical boards should clarify through communications, in print and online, that an investigation is not the same as a disciplinary undertaking**. Achieving an understanding of this distinction among licensees may help begin to dispel the stigma associated with reporting burnout and remove a barrier to physicians seeking help in times of need.

8. **State medical boards are encouraged to maintain or establish relationships with a PHP in their state and to support the use of data from these programs in a board's decision-making**.

9. **State medical boards should examine the policies and procedures currently in place for working with physicians who have been identified as impaired in a context that is meaningful for the provision of safe care to patients to ensure that these are fair, reasonable, and fit for the purpose of protecting patients. All such processes should be clearly explained and publicly available.**

10. **State medical boards should be aware of potential burdens placed on licensees by new or redundant regulatory requirements**. They should seek ways of facilitating compliance with existing requirements to support licensees and ensure that they are able to spend time with patients and in those areas of medicine which they find most meaningful. "Reducing the cumulative burden of rules and regulations may improve professional satisfaction and enhance physicians' ability to focus on patient care."[60]

Upon implementing some or all of the above changes to state medical board policy or processes that are meant to reduce the stigma associated with mental health issues and encourage treatment-seeking, the board should communicate these, and their rationale, to current and prospective licensees, as well as patients and the public. State medical boards should also raise the issue of physician burnout more often, emphasizing the importance

[60] Friedberg MW, et al. (2013). Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy. RAND Corporation, https://www.rand.org/pubs/research_reports/RR439.html.

of physician wellness, help-seeking, and the availability of accessible, confidential, and private counselling programs for physicians and all health professionals.

For External Stakeholders and Partner Organizations:

Professional Medical Organizations and Societies:

11. Professional medical societies at local, state, and national levels have a key role to play in encouraging physicians to seek treatment, both preventive and curative, for the physical and mental health issues they face, as well as for features of burnout. The FSMB recognizes the many exemplary programs and initiatives of professional medical societies and encourages their continued advocacy for physician wellness and the availability of support and treatment services.

12. The FSMB recommends a sustained focus in the medical profession on the importance of self-care with an aim to reduce the stigma attached with seeking treatment for health issues, particularly ones related to mental health.

13. The FSMB recommends that attempts be made to expand the availability of accessible, private, and confidential counseling for physicians through medical societies, such as those provided by organizations like the Lane County Medical Society (Oregon), which has a program with several features identified as best practices for physician wellness by the Workgroup. Counseling via telehealth could also enhance access and provide greater assurance of privacy to those seeking care.

14. Given the prevalence of burnout, all physicians need to be educated about the resources currently available regarding burnout, including those referenced in Appendix A, for self-awareness, and for identification and referral of peer professionals who may have burnout. Medical societies are encouraged to partner with other organizations identified in this report to improve awareness of resources and their dissemination.

15. The FSMB recommends that professional medical societies and organizations representing physicians, such as the American Medical Association, the American Osteopathic Association, and the Council of Medical Specialty Societies work with state medical boards to raise awareness among the public of the importance of physician wellness not only because of its inherent value to physicians themselves but also as a significant contributor to patient safety.

Centers for Medicaid and Medicare Services:

16. The FSMB recommends careful analysis of any new requirements placed on physicians to determine their potential impact on physician wellness. Any new

requirements that could serve as a driver of burnout in physicians must be supported by evidence and accompanied by a strong rationale that is based in improving patient care to justify any new burdens imposed on physicians.

State Government, Health Departments, and Legislatures:

17. As state government, health departments, and legislatures make decisions that can impact physicians, the FSMB recommends that they weigh the potential value of proposed new regulations against potential risks to the health of physicians and other clinicians.

Vendors of Electronic Health Records (EHR) systems and standard setting organizations:

18. As a promising advancement in the provision and documentation of care, but also a key driver of frustration with medical practice, EHRs need to be improved in a way that takes the user experience into greater consideration than it does currently. This experience may be improved through facilitating greater ease of data entry into the system, as well as ease of access to data from the system. Vendors are encouraged to include end-user physicians on their builder teams to optimize input about operability and interoperability.

19. Efforts to reduce redundant or duplicative entry should be required by standard setting organizations, such as the Office of the National Coordinator for Health IT (ONC), and reflected in the EHR systems ultimately designed by vendors.

20. EHR vendors are encouraged to focus future improvements on facilitating and improving the provision of patient care. The primary purposes of an EHR relate to documentation of care received by a patient, retrieval of patient care related information and data, and patient communication.

Medical Schools and Residency Programs:

21. The FSMB encourages the Accreditation Council for Graduate Medical Education, the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, the American Medical Association, the American Osteopathic Association and the institutions they represent, to continue their laudable efforts at improving the culture of medicine and facilitating open conversations about illness and wellness in order to promote positive change.

22. The FSMB recommends continued efforts to encourage medical students and residents to value self-care and understand the positive impacts that physician wellness can have on patient care.

23. The FSMB recommends that medical schools, residency programs, and their accrediting bodies consider ways of amplifying the medical student and resident voice on systemically induced pressures and support trainees by providing means for raising issues related to medical student and resident health and well-being anonymously.

Hospitals/Employers:

24. The FSMB recommends that hospitals revise, where necessary and appropriate, their questions asked as part of their credentialing process according to the recommendations made above for the medical licensing community to ensure that these are not discouraging physicians or other health professionals from seeking needed treatment.

25. The FSMB recommends that hospitals and health systems assess physician health at regular intervals using a validated instrument and act upon the results. Employers should keep results of these assessments internal to the organization or health system in order to promote workplace change, while avoiding threatening or punitive cultures.

26. Hospitals, as well as the American Hospital Association and related organizations, are encouraged to officially adopt the "Quadruple Aim" to demonstrate the importance they place in the health and wellness of the physicians and all other health professionals they employ and recognize the impact of provider health on safe patient care.

27. Hospitals should ensure that their policies and procedures are adopted with consideration given to the impact they have on the health of the hospital workforce. Decisions impacting hospital the health of hospital and health system employees should be made with adequate input from individuals representing the impacted sectors of that workforce.

28. While acknowledging the need for hospitals to acknowledge all staff in their programmatic development, employers are encouraged to make resources and programs available to physicians, including time and physical space for making connections with colleagues and pursuing personal goals that add meaning to physicians' work lives. Resources and programs should not always be developed and implemented in a "one size fits all" manner, but should incorporate consideration of the different stressors placed on male and female physicians, within and outside of the workplace, and be tailored appropriately. Resources related to EHR implementation and use should also be made available by employers, including training to optimize use and support for order-entry such as scribes or other technological solutions aimed at restoring time available to physicians.

29. Hospitals should ensure that mandatory reports related to physician competence and discipline are made available to state medical boards and other relevant authorities.

Insurers:

30. The FSMB recommends that insurance carriers revise, where necessary and appropriate, their questions on applications for professional liability insurance according to the recommendations made above for the medical licensing community to ensure that these are not discouraging physicians or other health professionals from seeking needed treatment.

31. In evaluating the quality of care provided by physicians, insurers should look beyond cost-saving measures and use metrics related to physician health and incentivize practice patterns that contribute to physician wellness.

Accrediting Organizations:

32. In its ongoing development of standards for the accreditation of undergraduate medical education programs, graduate medical education training programs, hospitals and healthcare facilities, the FSMB encourages those organizations charged with the accreditation of institutions and educational programs to include standards related to required resources and policies aimed at protecting medical student, medical resident and attending physician health.

Physicians:

33. Physician wellness is a complex issue, made up of system-wide and individual components. However, physicians have a responsibility to attend to their own health, well-being, and abilities in order to provide care of the highest standard.[61] This involves a responsibility to continually self-assess for indicators of burnout, discuss and support the identification of health issues with peers, and seek help or treatment when necessary. Physicians are encouraged to make use of services of state Physician Health Programs, which, where available, can be accessed confidentially in instances where patient harm has not occurred.

34. Physicians are encouraged to inform themselves about their ethical duty, oftentimes codified in state statutes, to report issues related to incompetence and unsafe care delivered by their peers. They are also encouraged to engage in open

[61] General Assembly of World Medical Association at Geneva Switzerland. (1948). *Declaration of Geneva,* as amended by the WMA General Assembly, October 2017.

dialogue with peers about the importance of self-care, treatment-seeking, and the threats to themselves and their patients presented by burnout.

35. Physicians are also encouraged to seek an appropriate balance between time spent on practice and related work and activities external to work, particularly ones with restorative potential.

Conclusion

The duty of state medical boards to protect the public includes a responsibility to ensure physician wellness and to work to minimize the impact of policies and procedures that impact negatively on the wellness of licensees, both prospective and current. The rationale for this duty is based on the link between physician burnout and its intendant risks to patient safety, the fact that some regulatory processes employed by state medical boards can have negative impacts on the health and wellness of physicians themselves, and the potential for regulatory change to support physician wellness and help prevent further instances of burnout.

The information and recommendations in this Report of the FSMB's Workgroup on Physician Wellness and Burnout are meant to support initial steps in the medical regulatory community and to contribute to ongoing conversation about patient safety and physician health.

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APPENDIX A: SAMPLE RESOURCE LIST

The following list is offered as a sample of resources available to support and facilitate the understanding, diagnosis, treatment, and prevention of symptoms of burnout or to maintain and improve physician wellness. The FSMB has not conducted an in-depth evaluation of individual resources, and inclusion herein does not indicate, nor is it to be interpreted as, an endorsement or guarantee of quality. Further, while some resources listed below are available free of charge, others are only accessible through purchase.

Federation of State Medical Boards, Policy on Physician Impairment, 2011.

Federation of State Medical Boards: Americans With Disabilities Act of 1990. License Application Questions: A Handbook for Medical Boards. Dallas, TX: Federation of State Medical Boards of the United States, Inc., 2006.

The standard tool used to evaluate rates of burnout is the Maslach Burnout Inventory, developed in the 1980s by Christina Maslach, PhD, a psychologist at the University of California Berkeley.

The HappyMD.com – in particular, the burnout prevention matrix, 117 ways to prevent burnout

Accreditation Council for Graduate Medical Education – Physician Wellbeing Resources

American Academy of Family Physicians - Physician Burnout Resources Page:

American College of Emergency Physicians (ACEP) – ACEP Wellness Resource page

American College of Physicians – Resources on Physician Well-Being and Professional Satisfaction

American Medical Association Steps Forward website:

American Osteopathic Association – AOA Physician Wellness Strategy

Association of American Medical Colleges – Wellbeing in Academic Medicine

Federation of State Physician Health Programs

Mayo Physician Well-being Program:

National Academy of Medicine Action Collaborative on Clinician Well-Being and Resilience

Remembering the Heart of Medicine

Stress Management and Resiliency Training (SMART) program

SuperSmartHealth

The Studer Group

The Well-Being Index (Mayo Clinic)

Policy on Physician Illness and Impairment: Towards a Model that Optimizes Patient Safety and Physician Health

Section I – Introduction

In April 2019, Chair of the Federation of State Medical Boards (FSMB), Scott Steingard, DO, established the *FSMB Workgroup on Physician Impairment* to review, in collaboration with the Federation of State Physician Health Programs (FSPHP),[1] the FSMB Policy on Physician Impairment (HoD 2011) and make recommendations to revise and expand the policy in light of new and emerging issues, including but not limited to:

1. implementation of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (May 2013);
2. use of medication for the treatment of opioid use disorder by practicing licensees with opioid use disorders;
3. the role of Physician Health Programs (PHPs) to promote licensee wellness and combat burnout;
4. state medical board policies and procedures designed to ensure appropriate working relationships with PHPs;
5. revised PHP Guidelines (2019) by the FSPHP.

This policy provides guidance to state medical and osteopathic boards (referred to hereinafter as state medical boards) for including PHPs in their efforts to protect the public. There is a need to educate the medical profession and the public about physician illness, impairment, and illness that can lead to impairment. This document represents recommendations for medical boards and PHPs to effectively protect the public through the assistance of licensees, medical students, and trainees with functionally impairing illness(es) based on best practices.

Section II - Model Physician Health Program (PHP)

State medical boards are referred to the Federation of State Physician Health Programs (FSPHP) Physician Health Program Guidelines[2] which, along with this document, serve as a resource in selecting and evaluating any particular PHP. Implementation of these Guidelines will necessarily vary from state to state in accordance with state legal, contractual and/or regulatory requirements.[3]

The purpose of a Physician Health Program (PHP) is to guide the rehabilitation of potentially impaired and impaired physicians, other licensed healthcare professionals, or those in training suffering from substance use disorders, psychiatric, medical, behavioral or other impairing

[1] A PHP (Physician Health Program) is a confidential program of prevention, detection, intervention, rehabilitation and monitoring of licensees or those in training with impairing conditions, approved and/or recognized by the state medical board. The FSPHP's mission is to support physician health programs in improving the health of medical professionals, thereby contributing to quality patient care.

[2] Federation of Physician Health Programs, Physician Health Program Guidelines, 2019.

[3] Whenever possible, the medical boards and PHPs should work collaboratively in the development of effective laws and regulations in the promotion of PHPs for the benefit of the public.

conditions, including burnout, consistent with the needs of public safety. This involves the early identification, evaluation, treatment, monitoring, documentation of adherence, and advocacy, when appropriate, of licensees with potentially impairing illness(es), ideally prior to functional impairment. PHPs should provide services to both voluntary and board mandated referrals without bias and should not provide assistance or guidance for illness outside their scope and expertise. The provision of confidentiality offers an incentive for the medical community and others to confidentially contact the PHP prior to a physician's illness becoming functionally impairing.

Ideally, PHP services would include the following:

- Wellness programs that address physician health, stress management, burnout and early detection of at-risk behavior.
- Educational programs on topics, including but not limited to, the recognition, evaluation, treatment and continuing care of impairing conditions.
- Opportunities to conduct and participate in valid IRB-approved research.
- Educational resources for the profession, the public, and medical boards about the role and function of PHPs.

The decision of a current or future licensee to seek or accept PHP assistance and guidance should not, in and of itself, be used against the physician in disciplinary matters before the board. However, PHPs must report substantive non-adherence with PHP recommendations and monitoring agreements and make periodic reports regarding adherence based on ongoing documentation to appropriate individuals, committees, boards or organizations on behalf of licensees under PHP monitoring.

The dual role of protecting the public through licensing and sanctions as well as the provision of a mechanism for the successful rehabilitation of impaired physicians falls within the statutory public protection mandate of state medical boards. Furthermore, early detection, evaluation, treatment, and monitoring of a physician with an impairing illness enhances a board's ability to protect the public.

It is necessary that PHPs function in a stable environment insulated, as much as possible, from changing political pressures. PHPs must also have a clearly defined mission and avoid any potential negative impact resulting from leadership and/or philosophical changes within the state medical association, state medical board or others. Consequently, the Workgroup optimally recommends that state medical boards enter into agreements with PHPs that have an independent organizational governance structure that prioritizes and allows for the fulfillment of the PHP mission.

Support for the PHP model from state medical boards and medical associations is essential for PHP effectiveness. PHPs and their boards of directors, medical associations and state medical boards should be aware of the competing nature of dual interests, understand the need for separation, and mitigate conflicts of interests where possible by maintaining appropriate boundaries between the medical association, the PHP and the state medical board.

A PHP should be empowered to take action based on verifiable signs and behaviors suggestive of impairment. Unlike the board, which must build a case capable of withstanding legal challenge, a PHP can quickly intervene based on a reasonable concern. The PHP can, therefore, be a significant benefit to public safety. Since 1995, FSMB policy has supported physician remediation via an effective PHP as an alternative to, or in conjunction with, sanctions.

Section III – State Medical Boards and PHPs

The goals and missions of the FSMB, FSPHP, and their partners align in many ways. This is especially true with respect to a desire to see healthy physicians providing excellent care to the patients they serve. While the PHP model is not the only feasible model for supporting impaired or potentially impaired physicians to safely return to practice, PHPs have developed experience and expertise in matters of physician health, they offer a therapeutic alternative to discipline where patient safety is not at risk, and they help encourage physicians to seek treatment early for impairing conditions. PHPs coordinate and monitor intervention, evaluation, treatment and continuing care of the impaired physician as well as those with impairing illnesses.

PHPs, regulatory agencies, and physicians agree that public protection is paramount. Yet, patient safety and physician wellness do not need to be at odds.[4] As stated in the FSMB policy on Physician Wellness and Burnout, "the duty of state medical boards to protect the public includes a responsibility to ensure physician wellness and to work to minimize the impact of policies and procedures that impact negatively on the wellness of licensees, both prospective and current."[5] Safe reintegration of the recovering physician back into the workforce constitutes the ideal scenario. At times, tension may arise among stakeholders regarding an appropriate balance between the goals of protecting the public, on the one hand, and assisting the physician in recovery, on the other. Collaboration among all stakeholders is required to effectively support physicians with impairing illness so that they may provide quality care to patients.

These efforts require that PHPs have a primary commitment to uphold the mission of their state medical and osteopathic boards in order to protect the public. To gain the confidence of regulatory boards, PHPs must develop quality reviews to enhance the effectiveness of their programs that demonstrate an ongoing track record of ensuring safety to the public and reveal deficiencies if they occur. Such transparency and accountability to the medical and osteopathic boards is necessary to the existence and continuation of a viable PHP.

The ideal relationship between a state medical board and a PHP is characterized by:

1. A commitment between both parties to open lines of communication and collaboration within the bounds of applicable confidentiality protections.

2. Mutual understanding of each organization's responsibility to program participants and the public.

3. No discrimination nor denial of PHP services based on a physician's race, creed, color, national origin, religion, sexual orientation, gender, gender identity, specialty, type of professional degree, or membership affiliations.

4. PHP acceptance of physician participants experiencing financial difficulties who otherwise meet program eligibility criteria, and availability for referrals by boards and other individuals or entities in need of services.

5. State medical board endorsement of a PHP and support to ensure the PHP has adequate staff and funding to meet its expected mission and goals.

6. PHP arrangement for emergency interventions and evaluations, where possible.

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[4] Lemaire JB, Ewashina D, Polachek AJ, Dixit J, Yiu V (2018) Understanding how patients perceive physician wellness and its links to patient care: A qualitative study. PLOS ONE 13(5): e0196888. https://doi.org/10.1371/journal.pone.0196888

[5] Federation of State Medical Boards *Policy on Physician Wellness and Burnout*, Adopted April 2018.

7. PHP establishment of a health monitoring agreement template designed to optimize continuing care, physician rehabilitation and patient safety. Details of each agreement should be individualized and subject to change based on case specifics.

8. Periodic review of laws and regulations by state medical boards, in consultation with PHPs, to ensure that the PHPs are legally able to adapt to evolving best practices.

A formal agreement should be executed between the state medical board and PHP, establishing the parameters of the relationship. Ideally, such an agreement will be based on the principles of mutual trust, respect, accountability, collaboration, and communication. Transparency of program policies and procedures while maintaining the appropriate confidentiality of individual participants is important.

Section IV – Supporting Physician Health: Key Considerations

For the purposes of this policy, physician impairment is defined as the inability of a physician to provide medical care with reasonable skill and safety due to illness or injury. The discussion of impairment in this policy applies to physicians broadly and includes not only licensed physicians and physician assistants, but also medical students, residents and fellows, and those seeking licensure. It also applies to other healthcare providers in instances where state medical boards license multiple types of healthcare professional.

It is important to distinguish illness from impairment. Illness, per se, does not constitute impairment.[6] When functional impairment exists, it is often the result of an illness in need of treatment. Therefore, with appropriate treatment, the issue of impairment may be prevented or resolved while the diagnosis of illness may remain.

Impairment is a functional classification which exists dynamically on a continuum of severity and can change over time rather than being a static phenomenon. At one end of this continuum can be found mild loss of function such as minimal cognitive decline, minor physical ailments, and other issues which do not, or which minimally, impact performance. At the other end of the continuum can be found more substantial loss of function such as that associated with severe cognitive decline, severe substance use disorder, or major physical, mental or emotional impairments that significantly limit the ability of a physician to provide safe medical treatment to patients. The location of a particular instance of loss of function along this continuum of severity is dictated by its impact on the functional ability of the physician to safely engage in the provision of medical care. An instance of loss of function only merits regulation by a state medical board if it meaningfully limits (and therefore impairs) a physician's ability to provide safe care to patients.

Any impairment should be evaluated according to the particular context of the physician's occupation, their specialty, and the patients and conditions they treat. An essential tremor in a surgeon could be considered a relatively severe impairing condition, whereas it may not be an impairment for a psychiatrist. Each particular instance of impairment should also be considered according to its severity and functional impact. For example, not every tremor would be too severe to perform simple procedures. Very minimal instances of cognitive impairment may not be significant enough to present risks to patient safety. In many cases, impairments can be improved through effective management.

[6] Candilis PJ, Kim DT, Snyder Sulmasy L, (2019) Physician Impairment and Rehabilitation: Reintegration into Medical Practice While Ensuring Patient Safety: A Position Paper from the American College of Physicians, *Ann Intern Med*. 170:871-9

Stigma and Barriers to Treatment

The stigma associated with illness and impairment, particularly impairment resulting from mental illness, including substance use disorders, can be a powerful obstacle to seeking treatment, especially in the medical community where the presence of this stigma has been described in the literature.[7] Many physicians are averse to seeing themselves in the role of the patient. Physicians may fear the impact that a diagnosis of impairing illness might have on the perceptions of their peers, patients, and others, including their state medical board, regardless of earnestness on the part of boards in treating people fairly and respectfully. This stigma is compounded and perpetuated by questions on applications for licensing, employment, credentialing and recredentialing, and malpractice insurance that inquire about mental health diagnosis and previous treatment. This fear presents significant risks not only to the potentially impaired physician's own health, but also to the safety of their patients.

Reducing the stigma associated with illness and impairment is essential for ensuring that physicians with impairing illness feel comfortable seeking treatment in order to practice safely, or to re-enter practice after a period of treatment and rehabilitation. As recommended in the FSMB Policy on Physician Wellness and Burnout,[8] boards are encouraged to take advantage of opportunities to discuss physician wellness, communicate regularly with licensees about relevant board policies and available resources, and help engender positive cultural change to reduce stigma associated with impairment among those physicians seeking treatment, as well as stigma related to the treatment itself and acknowledging its need. Beyond discussion, boards are encouraged to find ways to promote health, rehabilitation and restoration, and reduce obstacles to seeking treatment, including by allowing treatment to be sought confidentially for impairing illness and not requiring this to be reported as part of the licensing process, while reminding licensees of their professional responsibility to address any health concerns and ensure patient safety. Physicians must be afforded the same access to care as the general public. When boards achieve positive change in these areas, they are encouraged to communicate this to licensees and the public to ensure greater awareness and protect licensees' ability to address health conditions without stigma or delay.

Assessment of Impairment

While each instance of impairment would need to be assessed based on its individual signs and behaviors, there are common features which might indicate impairment in any physician. For example, if a physician is suffering from impairment due to substance use, this may become apparent through changes in mood/affect, decreased productivity, apathy toward patient care, suicidal ideation or behavior, increasing medical errors, inconsistent hours, complaints from patients or other colleagues, deterioration in appearance or physical health, and changes in social interactions.[9] An overall pattern or cluster of signs and behaviors would be more indicative of an individual at imminent risk for impairment than individual and isolated events.

Medical Students, Residents and Fellows

It has been shown that students whose professionalism lapses in medical school are more likely to exhibit similar behaviors in residency training and practice.[10] Fostering greater understanding of the regulatory role in physician impairment and the purpose of PHPs, encouraging self-care and seeking treatment early among medical students, residents and fellows ("residents and fellows" are

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[7] Wallace, JE (2012) Mental Health and Stigma in the Medical Profession, *Health:*, 16(1): 3-18.
[8] Federation of State Medical Boards *Policy on Physician Wellness and Burnout*, Adopted April 2018.
[9] Santucci, Karen. Reporting an impaired colleague difficult but necessary. AAP News, 2018. https://www.aappublications.org/news/2018/11/28/law112818
[10] Krupat E, Dienstag JL, Padrino SL, Mayer JE, Shore MF, Young A, Chaudhry HJ, Pelletier SR, Reis BY, Do Professionalism Lapses in Medical School Predict Problems in Residency and Clinical Practice? *Acad Med*: June 2020, Vol.95(6):888-895.

hereinafter referred to as "residents", unless otherwise specified) and facilitating dialogue between state medical boards and the medical education community are therefore important elements of patient protection.

Stigma associated with mental health issues and impairment is negatively correlated with adaptive attitudes about help-seeking among medical students, especially those who are already having difficulties.[11] In considering the multitude of issues facing medical students and residents, including burnout, financial difficulties, educational stressors, geographic isolation, and a lack of support systems, supportive resources become invaluable. It is of the utmost importance to promote an awareness of how and when to access these resources. The crucial work of the FSMB's Workgroup on Physician Wellness and Burnout is applicable to medical students and residents and their professional development as well.

The development and provision of resources to help identify and prevent impairment in medical students is not in the direct purview of state medical boards. However, there are strategies boards may wish to implement to encourage and facilitate seeking treatment across the continuum of medical students, residents and practicing physicians. Among these are avoiding the inclusion of questions about current medical or psychiatric conditions or counseling, or previous history of impairment on applications for medical licensure, or offering a "safe haven" alternative of not reporting treatment sought either through the PHP model or a physician expert model that involves comprehensive care management and monitoring. Again, these should be replaced with reminders of the importance of physician wellness, and positive developments in these areas should be promoted widely through communications strategies to raise awareness, reduce stigma, and dispel myths about the ways in which state medical boards approach the issue of impairment.

State medical boards can also be supportive of medical schools relative to the early detection, prevention, evaluation and treatment of impairing conditions according to the same principles of confidentiality, collaboration, communication, accountability, professional assistance, and guidance adopted by the PHP community. These principles are indispensable during transition periods in training such as between medical school and residency and between residency and entry to independent or unsupervised practice. The concept of "warm handover"[12] during these periods, subject to a student's or resident's consent and after they have been accepted into a residency or fellowship program, that includes a confidential and appropriate focus on student well-being can be encouraged by the medical regulatory community.

Medical students, residents, and training programs can also benefit from greater availability of information about the considerations, processes and timelines used by state medical boards in arriving at licensing decisions related to impairment. While boards consider each instance of impairment based on the physician's individual context, transparent information about the considerations that factor into boards' decisions can help foster an appreciation for a consistent approach among boards and reduce anxiety associated with the licensing processes among applicants. It could also help reduce stigma associated with impairment and encourage treatment seeking.

State medical boards can also encourage greater awareness of their purpose and procedures by inviting students to attend board meetings and engaging in outreach with medical schools. The concept of student attendance at board meetings has already been adopted by several boards across the country and presents valuable opportunities to foster familiarity with the board and educate about the importance of seeking treatment, the continuum of (and differences between) illness and impairment, the value of early intervention, and the fact that illness can be treated in a safe,

[11] Schwenk TL, et al. (2010). Depression, Stigma, and Suicidal Ideation in Medical Students. JAMA, 304(11):1181-1190.

[12] Warm, Eric J. MD; Englander, Robert MD; Pereira, Anne MD, MPH; Barach, Paul MD, MPH. Improving Learner Handovers in Medical Education. *Acad Med*: July 2017, Vol.92(7):927-931

confidential, respectful and professional manner without impact on the ability of the medical student to continue their education and ultimately obtain an unrestricted medical license. A greater understanding of these and other medical regulatory concepts can also be gained through the free online educational modules developed by the FSMB which are geared towards medical students and residents. Better educated and informed medical students become better residents who are more aware of their own well-being and behavioral and mental health needs and are better able to serve themselves and their patients after they complete their training.

Reporting

It is essential that state medical boards have timely information about instances of a physician practicing while impaired in order for them to carry out their patient protective functions. Gathering such information about all instances of practicing while impaired is not always possible in the course of state medical boards' typical regulatory processes. Boards will therefore depend on licensees and other individuals and entities to fulfill their ethical "duty to report" such instances. This is a duty of physicians and the profession of medicine to patients and society, to help ensure patients are provided safe medical care and that trust in medicine is maintained. It is also a duty to impaired physicians, as reporting aims to encourage physicians in seeking the assistance, guidance and support they need in order to continue practicing safely.

Some instances of practicing while impaired will require direct reports to state medical boards, including instances of patient harm and substantive non-adherence to agreements with PHPs. However, when a timely intervention to ensure that an impaired physician ceases practicing and receives appropriate PHP assistance is sufficient to protect patients, the ethical duty towards patients and colleagues has been discharged.[13]

While this ethical duty to intervene transcends state lines, legal requirements for reporting vary among states. Language used in state laws indicating when reporting an instance of impairment in a physician colleague is required can include "actual knowledge" of an impairment, "reasonable cause" to believe that an impairment exists, "reasonable belief" that an impairment is present, "first-hand knowledge" of an impairment, and "reasonable probability" (as distinguished from "mere probability") of an impairment.[14] Licensees should be expected to be familiar with reporting requirements in the state(s) in which they are licensed. State medical boards can support licensee understanding of reporting requirements by developing guidance documents in lay rather than legal terms. Where boards are permitted to work with legislatures on drafting or amending legislation, they may wish to ensure clear language regarding reporting requirements that emphasizes the theme of "reasonability." If it is reasonable to believe that a physician is impaired in such a way that they pose a threat to patient safety, then reporting should be required.

Reporting responsibilities also exist between PHPs and state medical boards. Reporting requirements may vary from state to state based on state laws, program regulations, as well as the relationship and level of trust between the PHP and the board. The PHP should report to the board on the status of program participants in accordance with the agreement between the board and the PHP. Some boards require periodic reports on participants **they have referred** to the PHP. Others may ask for reports on all participants. In that case, board mandated participants are identified by name while confidential participants are identified by number to maintain their confidentiality. Confidential PHP participants (those that are unknown to the board and/or those for whom there is no reporting requirement) risk forfeiting their confidentiality should they have substantive non-adherence to an agreement with their PHP, and will forfeit their confidentiality should they pose a risk to the public. PHPs reporting on

[13] AMA Code of Medical Ethics, Opinion 9.3.2

[14] Starr, Kristopher T Reporting a Physician Colleague for Unsafe Practice: What's the Law? *Nursing2019*: February 2016 - Volume 46 - Issue 2 - p 14

those physicians who are board-mandated may report to the board on a periodic basis and include detailed reports on adherence to continuing care plans and monitoring results.

Referral

State medical boards should offer two separate tracks for referral of ill or impaired physicians to PHPs: a voluntary track and a mandated track.

Voluntary Track – A confidential process of seeking assistance and guidance through a PHP whereby the impairing illness is addressed without required personal identification to the state medical board. A voluntary track promotes earlier detection of potentially impairing illness before it becomes functionally impairing. The voluntary track participants are in a safe system whereby substantive non-adherence or relapse, depending on each state's non-adherence reporting requirements, will be promptly reported to the licensure board by name.

Mandated Track – Mandated licensees are those required by the state medical board to participate in a PHP. A mandated referral can be via an informal referral or via a formal public or private censure. In either instance the board may require quarterly progress reports. It is recommended that boards have a non-disciplinary process for referral to encourage early detection and intervention.

FSMB encourages referral to PHPs as an alternative to discipline to facilitate early detection, evaluation, treatment and monitoring before illness progresses to actual impairment. Non-disciplinary tracks also encourage self-referrals and more referrals by concerned colleagues, family members and patients.

FSMB recognizes that, for a variety of reasons, treatment of healthcare professionals may occur with or without oversight by a PHP. As recommended by the American Society of Addiction Medicine, "clinicians who treat healthcare professionals outside of PHPs should thoughtfully appraise their ability to provide credible assurance of safety to practice for professionals in their care and understand their legal and ethical requirements for public safety within the context of the therapeutic relationship. Clinicians with expertise in the treatment of healthcare professionals with (impairing illness) should understand when participation in a PHP may offer an advantage to (the physician-patient) and (utilize) this additional support."[15]

Criteria for Referral for Professional Assessment

One or more of the following should prompt referral of the physician, for additional screening and diagnostic assessment by a qualified professional evaluator:

1. Information or documentation of a medical condition that impairs the ability to practice medicine with reasonable skill and safety.

2. Information or documentation of excessive use of alcohol or other potentially impairing drugs, regardless of addictive potential (e.g., antipsychotics, anticholinergics, anticonvulsants, hallucinogens, stimulants)

3. Sufficient indications of current alcohol or other drug use that may include positive toxicology results for substances that are not prescribed by a treating healthcare professional.

[15] American Society of Addiction Medicine, Public Policy Statement on Physicians and other Healthcare Professionals with Addiction, Adopted by the ASAM Board of Directors February 6, 2020.

4. Behavioral, affective, cognitive, or other mental problems that raise reasonable concern for public safety.

5. Information or documentation of psychiatric illness or substance use disorder that impairs the ability to practice.

Evaluation and Diagnosis

PHPs accept self-referrals and calls from collateral sources who may be concerned about a physician. PHPs will gather the necessary information and guide the next steps. Evaluation of a physician may involve referral for a comprehensive clinical and/or multidisciplinary examination. The nature and content of the evaluation will be dictated by the specific circumstances of the physician being evaluated, their reasons for referral, and any concerns raised by the referring entity or individual. For suggestions on specific evaluation criteria, as well as credentials of the evaluator or evaluating team, state medical boards may wish to consult the FSPHP Guidelines.[16] High quality evaluations and treatment options are essential to the successful rehabilitation of providers. As such, state medical boards and PHPs should collaborate to ensure that evaluations of fitness to practice are carried out according to best practices and completed in a timely manner.

Treatment/Rehabilitation

Ensuring that physicians experiencing impairment are appropriately treated and rehabilitated in order to safely reenter practice is part of the mandate of state medical boards. The specific course of treatment and monitoring for rehabilitation of the individual physician participant, however, is under the purview of the treating healthcare professional and PHP, respectively.

In accordance with applicable statutory reporting requirements, PHPs, evaluators and treatment providers must report to the board any physician who is substantively non-adherent to the recommendations of a treatment agreement and poses a reasonable risk to patient safety.

Medications for the Treatment of Opioid Use Disorder

Medications for the Treatment for Opioid Use Disorder (MOUD) refers to the medications that are FDA-approved for the treatment of Opioid Use Disorder (OUD), including methadone, buprenorphine, and naltrexone. These medications are used in combination with an array of counseling, psychiatric, medical and psychosocial and/or spiritual therapies, and recovery support services based on a thorough assessment of individual needs. MOUD is recognized as being the standard of care for OUD and an important component of quality treatment.[17,18]

Methadone:
Methadone is a full opioid agonist[19] and an effective treatment for chronic pain and suppression of symptoms of opioid withdrawal and for treatment of OUD. While

[16] Federation of Physician Health Programs, Physician Health Program Guidelines, 2019.
[17] ASAM National Practice Guideline for the Treatment of Opioid Use Disorder, 2020 Focused Update.
[18] Substance Abuse and Mental Health Services Administration. *Medications for Opioid Use Disorder*. Treatment Improvement Protocol (TIP) Series 63. Publication No. PEP20-02-01-006. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.
[19] For definitions of opioid agonist, antagonist, and partial agonist, see Substance Abuse and Mental Health Services Administration. *Medications for Opioid Use Disorder*. Treatment Improvement Protocol (TIP) Series 63. Publication No. PEP20-02-01-006. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020, p.1-2, Exhibit 1.1. Key Terms.

methadone is an effective treatment for OUD in the general population,[20,21] its characteristics include the potential for cognitive impairment until tolerance has developed.[22]

Buprenorphine:
Buprenorphine is a partial opioid agonist and is an effective treatment for suppression of symptoms of opioid withdrawal and for treatment of OUD. When buprenorphine is administered appropriately, it has minimal effects which would cause impairment.[23] New injectable buprenorphine formulations eliminate diversion risks associated with sublingual formulations.

Naltrexone:
Naltrexone is an opioid antagonist that is an effective treatment used to prevent relapse to opioid use in patients who are no longer physically dependent on opioids. Naltrexone can be administered orally or as time-release injections. Oral naltrexone has not been demonstrated to be an effective treatment for OUD in studies thus far. Long-acting injectable naltrexone outcomes in a 6-month study are similar to those for buprenorphine for patients who successfully initiate the medication.[24]

Substance use disorder (SUD) treatment is most effective when it involves a multimodal approach including evidence-based medical care, psychosocial interventions, and mutual support groups within a chronic disease management model, inclusive of toxicology testing.[25] Physicians and other health care professionals are safety-sensitive workers. It is recognized that safety-sensitive work confers a benefit to society that is not without risk to public safety. As such, safety-sensitive workers, organized medicine, and regulatory agencies have an ethical and legal obligation to take preventive measures to minimize identifiable safety risks and are accountable when harm occurs.

Physicians are just as susceptible to OUD and addiction as the general population and deserve the same consideration in terms of their privacy, treatment and safety. However, the safety-sensitive nature of medical practice and patient care may impact which treatment options are most appropriate for physicians who suffer from OUD *and* wish to continue to practice medicine. Physicians and other clinicians should not be put in a special category of

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[20] Mattick RP, Breen C, Kimber J, Davoli M. Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. Cochrane Database Syst Rev. 2009;3:CD002209

[21] Madras, B. K., N. J. Ahmad, J. Wen, J. Sharfstein, and the Prevention, Treatment, and Recovery Working Group of the Action Collaborative on Countering the U.S. Opioid Epidemic. *NAM Perspectives.* Discussion Paper, Washington, DC. https://doi.org/10.31478/202004b

[22] Substance Abuse and Mental Health Services Administration. *Medications for Opioid Use Disorder*. Treatment Improvement Protocol (TIP) Series 63. Publication No. PEP20-02-01-006. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.

[23] Substance Abuse and Mental Health Services Administration. *Medications for Opioid Use Disorder*. Treatment Improvement Protocol (TIP) Series 63. Publication No. PEP20-02-01-006. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.

[24] Lee JD, Nunes EV Jr, Novo P, et al. Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention (X:BOT): a multicentre, open-label, randomised controlled trial. *Lancet*. 2018;391(10118):309-318. doi:10.1016/S0140-6736(17)32812-X

[25] Merlo LJ, Campbell MD, Skipper GE, Shea CL, DuPont RL. Outcomes for Physicians with Opioid Dependence Treated Without Agonist Pharmacotherapy in Physician Health Programs. *J Subst Abuse Treat*. 2016;64:47-54. doi:10.1016/j.jsat.2016.02.004

exclusion from treatment options that may effectively treat their addiction, but recognition of the safety-sensitive nature of their work is important. As such, decisions about whether it is safe to practice while receiving MOUD should include the following considerations:

- The potential for cognitive impairment[26] alone or in combination with other medications
- The potential for misuse or diversion of the medications
- The presence of co-occurring illness
- The relative importance and availability of complementary psychosocial treatments
- The feasibility of monitoring by a PHP or other physician expert with experience and expertise in the treatment and monitoring of physicians with SUD

As with any patient being assessed for MOUD, determination of the most appropriate course of treatment for a practicing physician should be based on the individual physician's case specific circumstances. Convenience, prescriber preference, and reimbursement rates should not outweigh considerations of patient safety, including both the physician as patient and the patients they treat if they continue to practice while receiving MOUD.

It is strongly recommended that physicians practicing medicine while taking a medication for OUD receive psychosocial treatment, including counselling and other treatment or services as determined based on their individual needs. These psychosocial treatments are often best understood and coordinated through PHPs or in collaboration with physicians with expertise in the treatment of physicians with addiction.[27] These programs and/or physician experts are also able to support physicians suffering from substance use disorders and associated co-occurring illness and can therefore provide comprehensive care management informed by experience and expertise of the unique needs of this cohort. PHPs represent a model for chronic disease management and monitor (longitudinally over time) health care practitioners who have health conditions that could impair their ability to safely practice, thereby mitigating this risk. The Workgroup recommends that state medical boards not require disclosure on licensing applications of treatment sought either through the PHP model or a physician expert model that involves comprehensive care management and monitoring.

Section V – Monitoring and Continuing Care

Monitoring agreements must be established between PHPs and participants. Agreements should clearly state the limits of confidentiality with respect to the PHP's statutory reporting obligations. Circumstances which would trigger a mandatory report to the state medical board, pursuant to statute or contract with the board, should be specified in the monitoring agreement. Reportable event(s) should result in notification of the board and appropriate others in a timely manner. Where abstinence from alcohol or other legal or illegal substances is required as part of a monitoring agreement, it should be understood as the complete avoidance of substances *that are not prescribed by a treating healthcare professional*.

[26] The opportunity for over and under dosing in patients receiving an opioid agonist or partial agonist is not readily detectable. Significant fluctuations in dosing can have negative effects on well-being and cognition.

[27] Available evidence has shown that physicians with OUD who are not treated with MOUD have low relapse and comparable success rates to other Substance Use Disorders under the PHP model of care (Merlo LJ, et al., *J Subst Abuse Treat*, 2016;64:47-54). These findings support the fact that long-term recovery from OUD is possible without the use of MOUD in the physician population.

The nature and duration of monitoring will vary based on the impairing illness of the PHP participant and should be informed by the conditions specified in the FSPHP Guidelines.

In the event of relocation of a participant, the PHP should have a mechanism to facilitate the transfer of monitoring to the appropriate state PHP or, in the absence of a PHP or board approved alternative, the licensing board. When a physician is licensed and working in more than one state, either the state of residence or the state in which most professional activities are occurring should agree to assume primary responsibility for monitoring with regular reports to the other state(s). Whenever possible, monitoring should not be duplicated.

Care that follows the acute phase of intervention and initial treatment is referred to as continuing care or aftercare. PHPs oversee and monitor the continuity of care of participants to ensure progress and continued adherence to treatment agreements. Continuing care includes PHP guidance, support, toxicology testing, and accountability through a formal monitoring agreement concurrent with or following an evaluation and treatment process.

Continuing care of the PHP participant is crucial to the successful recovery, safe return to the practice of medicine, and ultimately the successful completion of PHP participation. The board should receive regular monitoring adherence reports prepared by the PHP for all board mandated physicians.

Section VI – Conclusion

State medical boards fulfill their primary mission of protecting the public in many ways. One important way is by supporting the health and well-being of licensees so that they may provide quality care to patients. Boards promote the public health and safety when they ensure that tools and support are available to enable early detection, proper treatment, and professional continuing care of impaired physicians. Furthermore, early intervention with licensees with impairing illness may prevent progression of illness to overt impairment.

All stakeholders should become better informed regarding issues not only related to functional impairment but also to impairing illness. Ideally, state and federal law should facilitate the effective interface between boards, PHPs and physician experts in their effort to support the rehabilitation of licensees with impairing illness because it adds to public protection. State medical boards are encouraged, with input from their PHPs and other qualified experts, to revisit their Medical Practice Act routinely to ensure that it remains consistent with legislation and developments in the field.

Boards, PHPs, and non-PHP clinicians who care for physicians can support each other through developing relationships based on mutual respect and trust. When this occurs, the public benefits. A highly trained licensee who is safely rehabilitated is an asset to the medical community, the state, and the public.

Appendix A: Glossary of Key Terms

Physician Impairment
The inability of a physician to provide medical care with reasonable skill and safety due to illness or injury.

Physician Health Program
A confidential resource for physicians, other licensed healthcare professionals, or those in training suffering from or at risk of an impairing health condition. Such conditions include, but are not limited to, mental illness, including substance use disorders, non-psychiatric medical conditions and their treatments, and age-related cognitive and motor deterioration.

Substance Use Disorder
Substance use disorder (SUD) is a health condition marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use alcohol, nicotine, and/or other drugs despite significant related problems.[28]

Opioid Use Disorder
A substance use disorder involving opioids.

Medication for Opioid Use Disorder (MOUD)
Medications for the Treatment of Opioid Use Disorder (MOUD) refers to the medications that are FDA-approved for the treatment of Opioid Use Disorder (OUD), including methadone, buprenorphine, and naltrexone. These medications are used in combination with an array of counseling, other biological and psychosocial and/or spiritual therapies, and recovery support services based on a thorough assessment of individual needs. MOUD is recognized as the standard of care and an important component of quality treatment.[29,30]

Physician Expert Model of Treatment and Monitoring
A physician expert model of treatment and monitoring for clinicians with impairing illness is an alternative to the PHP model where a PHP either does not exist in a given state or is not appropriate for the treatment or monitoring of a particular participant. For example, some PHPs do not monitor physicians who have been treated for professional sexual misconduct and returned to practice. Such a model is only recommended as an alternative option for the treatment and monitoring of an impaired physician provided that it involves the evaluation, treatment, monitoring, documentation of adherence with a treatment agreement, and the duty to report impairment in the context of medical practice that are accepted elements of the PHP model.

Physician experts who provide treatment and monitoring through such a model should understand when participation in a PHP may offer an advantage to the physician-patient and utilize this additional support.[31]

Abstinence
Abstinence is defined as the complete avoidance of potentially impairing drugs that are not legitimately prescribed.

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[28]American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

[29] ASAM National Practice Guideline for the Treatment of Opioid Use Disorder, 2020 Focused Update.

[30] Substance Abuse and Mental Health Services Administration. *Medications for Opioid Use Disorder*. Treatment Improvement Protocol (TIP) Series 63. Publication No. PEP20-02-01-006. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.

[31] American Society of Addiction Medicine, Public Policy Statement on Physicians and other Healthcare Professionals with Addiction, Adopted by the ASAM Board of Directors February 6, 2020.

Relapse
A process in which an individual who has established disease remission experiences recurrence of signs and symptoms of active addiction, often including resumption of the pathological pursuit of reward and/or relief through the use of substances and other behaviors. When in relapse, there is often disengagement from recovery activities. Relapse can be triggered by exposure to rewarding substances and behaviors, by exposure to environmental cues to use, and by exposure to emotional stressors that trigger heightened activity in brain stress circuits. The event of using substances or re-engaging in addictive behaviors is the latter part of the process, which can be prevented by early intervention.[32] It is important to note that appropriate treatment of some participants may involve the use of prescription medications known to the PHP.

The FSPHP *Physician Health Program Guidelines* define three levels of relapse relevant to the monitored health professional which may be helpful to state medical boards:

- Level 1 Relapse: Behavior without chemical use that is suggestive of impending relapse
- Level 2 Relapse: Relapse, with chemical use, that is not in the context of active medical practice
- Level 3 Relapse: Relapse, with chemical use, in the context of active medical practice[33]

Substantive Non-Adherence
Substantive non-adherence is a pattern of non-adherence, dishonesty, or other behavior that compromises the integrity of PHP continuing care monitoring, or an episode of non-adherence which could place patients at risk.

[32] American Society of Addiction Medicine (ASAM). The ASAM National Practice Guideline For the Treatment of Opioid Use Disorder: 2020 Focused Update. Available at: https://www.asam.org/Quality-Science/quality/2020-national-practice-guideline
[33] Federation of Physician Health Programs, Physician Health Program Guidelines, 2019.

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AGENDA REQUEST FORM

1) Name and title of person submitting the request:	2) Date when request submitted:
Nilajah Hardin, Administrative Rules Coordinator	**06/03/22** Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting

3) Name of Board, Committee, Council, Sections:

Medical Examining Board

4) Meeting Date:	5) Attachments:	6) How should the item be titled on the agenda page?
06/15/22	☒ Yes ☐ No	**Administrative Rule Matters – Discussion and Consideration** **1. Med 13, Relating to Continuing Medical Education** **2. Pending or Possible Rulemaking Projects** **a. Rule Projects Chart**

7) Place Item in:	8) Is an appearance before the Board being scheduled? *(If yes, please complete Appearance Request for Non-DSPS Staff)*	9) Name of Case Advisor(s), if required:
☒ Open Session ☐ Closed Session	☐ Yes ☒ No	**N/A**

10) Describe the issue and action that should be addressed:

Attachments:
Scope Statement – Med 13
Wis. Admin. Code Med 13 with Proposed Changes
Rule Project Chart

(Board Rule projects can be Viewed Here if Needed: https://dsps.wi.gov/Pages/RulesStatutes/PendingRules.aspx)

11) Authorization

Nilajah D. Hardin — 06/03/22

Signature of person making this request — Date

Supervisor (if required) — Date

Executive Director signature (indicates approval to add post agenda deadline item to agenda) — Date

Directions for including supporting documents:
1. This form should be attached to any documents submitted to the agenda.
2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director.
3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.

STATEMENT OF SCOPE

Medical Examining Board

Rule No.: Med 13

Relating to: Continuing Medical Education for Physicians

Rule Type: Permanent

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

N/A

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

The Medical Examining Board will update ch. Med 13 to extend the requirement that 2 of the 30 required continuing medical education (CME) hours per biennium shall be in a course or program related to opioid prescribing into the biennium ending November 2023, and to modify the requirement to include courses or programs concerning controlled substances generally. Additionally, the Board will re-evaluate and modify or remove the requirement that educational programs related to opioid prescribing or controlled substances be pre-approved by the Board.

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

Chapter Med 13 currently requires that licensees take 2 hours of their 30 hours of required CME per biennium in courses or programs related to opioid prescribing for the biennium ending in November 2021. In order to continue this requirement into the next biennium, an update to the rule is required. The Board has also identified a need to re-evaluate the pre-approval requirement for courses or programs related to opioid prescribing.

The alternative of not conducting this evaluation and update would be to leave the rules unchanged, which would result in the requirement not continuing into the next biennium, and would limit the courses available to licensees.

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

Section 15.08 (5) (b), Stats., provides each examining board "[s]hall promulgate rules for its own guidance and for the guidance of the trade or profession to which it pertains. . ."

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

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

80 hours

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

Wisconsin licensed physicians and providers of continuing medical education for physicians

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

None.

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

The proposed rule will have minimal to no economic impact on small businesses and the state's economy as a whole.

Contact Person: Nilajah Hardin, Administrative Rules Coordinator, DSPSAdminRules@wisconsin.gov, (608) 267-7139.

Approved for publication:

Authorized Signature

3/29/2022

Date Submitted

Approved for implementation:

Authorized Signature

5/11/2022

Date Submitted

Chapter Med 13

CONTINUING MEDICAL EDUCATION FOR PHYSICIANS

Med 13.01 **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) (b), 227.11 (2) and 448.13, Stats., and govern the biennial training requirements for physicians as provided under s. 448.13, Stats.

History: Cr. Register, February, 1977, No. 254, eff. 3-1-77; am. Register, March, 1979, No. 279, eff. 4-1-79; correction made under s. 13.93 (2m) (b) 7., Stats., Register, May, 1989, No. 401; am. Register, May, 1997, No. 497, eff. 6-1-97; am. Register, December, 1999, No. 528, eff. 1-1-00.

Med 13.02 **Continuing medical education required; waiver. (1)** Each physician required to complete the biennial training requirements provided under s. 448.13, Stats., shall, in each second year at the time of making application for a certificate of registration as required under s. 448.07, Stats., sign a statement on the application for registration certifying that the physician has completed at least 30 hours of acceptable continuing medical educational programs within the biennial registration period.

~~**(1g)** (a) Except as provided under par. (b), for a renewal date occurring in 2017 or 2018, a minimum of 2 of the 30 hours of continuing medical education required under sub. (1) shall be an educational course or program related to the guidelines issued by the board under s. 440.035 (2m), Stats., that is approved under s. Med 13.03 (3) at the time of the physician's attendance.~~

~~(b) This subsection does not apply to a physician who, at the time of making application for a certificate of registration, does not hold a U.S. drug enforcement administration number to prescribe controlled substances.~~

~~**(1r)** (a) Except as provided under par. (b), for the renewal date occurring on November 1, 2019, a minimum of 2 of the 30 hours of continuing medical education required under sub. (1) shall be an educational course or program related to the guidelines issued by the board under s. 440.035 (2m), Stats., that is approved under s. Med 13.03 (3) at the time of the physician's attendance.~~

~~(b) This subsection does not apply to a physician who, at the time of making application for a certificate of registration, does not hold a U.S. drug enforcement administration number to prescribe controlled substances.~~

~~**(1v)** (a) Except as provided under par. (b), for the renewal date occurring on November 1, 2021, a minimum of 2 of the 30 hours of continuing medical education required under sub. (1) shall be an educational course or program related to opioid prescribing that is approved under s. Med 13.03 (3) at the time of the physician's attendance.~~

~~(b) This subsection does not apply to a physician who, at the time of making application for a certificate of registration, does not hold a U.S. drug enforcement administration number to prescribe controlled substances.~~

(1x) (a) Except as provided under par. (b), ~~for the renewal date occurring on November 1, 2023,~~ a minimum of 2 of the 30 hours of continuing medical education required under sub. (1) shall be an educational course or program related to prescribing opioids and other controlled substances that is approved under s. Med 13.03 (3) at the time of the physician's attendance, and whose subject matter meets the requirements of s. Med 13.03 (3) (b) 2s.

(b) This subsection does not apply to a physician who, at the time of making application for a certificate of registration, does not hold a U.S. drug enforcement administration number to prescribe controlled substances.

(2) A physician may apply to the board for waiver of the requirements of this chapter on grounds of prolonged illness or disability or other similar circumstances, and each case will be considered individually on its merits by the board.

History: Cr. Register, February, 1977, No. 254, eff. 3-1-77; am. (1), Register, March, 1979, No. 279, eff. 4-1-79; am. (1), February, 1981, No. 302, eff. 3-1-81; am. Register, May, 1997, No. 497, eff. 6-1-97; am. Register, December, 1999, No. 528, eff. 1-1-00; EmR1631: emerg. am. (1), cr. (1g), (1r), eff. 11-10-16; CR 16-070: am. (1), cr. (1g), (1r) Register May 2017 No. 737, eff. 6-1-17; CR 18-072: am. (1g), (1r), cr. (1v), Register July 2019 No. 763, eff. 8-1-19; **CR 21-017: cr. (1x) Register January 2022 No. 793, eff. 2-1-22.**

Med 13.03 **Acceptable continuing medical educational programs.** The board shall accept the following in satisfaction of the biennial training requirement provided under s. 448.13, Stats.:

(1) (a) *Program approval.* Educational courses and programs approved in advance by the board may be used for credit, except that the board may approve for credit completed programs and courses conducted in other countries.

(b) *Physicians.* The board recognizes only those educational programs recognized as approved at the time of the physician's attendance by the council on medical education of the American medical association, or the American osteopathic association, or the accreditation council for continuing medical education or may recognize program providers outside the United States unless any of the foregoing have been previously disapproved by the board. The board will accept attendance at and completion of programs accredited as the American medical association's or the American osteopathic association's "Category I" or an equivalent as fulfilling the requirements of this chapter for continuing medical education. One clock hour of attendance shall be deemed to equal one hour of acceptable continuing medical education.

(2) (a) The board shall accept for continuing medical education credit, voluntary, uncompensated services provided by physicians specializing in psychiatry in assisting the department of health services in the evaluation of community outpatient mental health programs, as defined in s. 51.01 (3n), Stats., and approved by the department of health services according to rules promulgated under s. 51.42 (7) (b), Stats. Four hours of assistance, including hours expended in necessary training by the department of health services, shall be deemed to equal one hour of acceptable continuing medical education for the purposes of this chapter.

(b) Physicians wishing to apply for continuing medical education credit under this subsection shall register in advance with the board and shall notify the board on forms provided by the board of the dates and the total number of hours in any biennium for which the applicant will be available to provide assistance. Referrals shall be made to the department of health services in the order received pursuant to requests for assistance received from that department by the medical examining board and by the psychology examining board.

Note: Forms to apply for continuing medical education credit are available from the department of safety and professional services' website at http://dsps.wi.gov, by phone at (608) 266-2112, or by email at dsps@wisconsin.gov.

(3) (a) Only educational courses and programs approved by the board may be used to satisfy the requirement under s. Med 13.02 ~~(1g) (a), (1r) (a), (1v) (a), and~~ (1x) (a). To apply for approval of a continuing education course or program, a provider shall submit to the board an application on forms provided by the department. The application shall include all of the following concerning the course or program:

1. The title.
2. A general description and a detailed outline of the content.
3. The dates and locations.
4. The name and qualifications of the instructor.
5. The sponsor.

Note: An application for continuing education course or program approval may be obtained from the board at the Department of Safety and Professional Services, Office of Education and Examinations, P.O. Box 8366, Madison, Wisconsin, 53708, or from the department's website at http://dsps.wi.gov.

(b) A continuing education course or program must meet all of the following criteria to be approved:

1. The course or program is accepted by the board under sub. (1) (b).
2. ~~The subject matter of a course under s. Med 13.02 (1g) (a) or (1r) (a) shall pertain to the guidelines issued by the board under s. 440.035 (2m), Stats.~~

2m. ~~The subject matter of a course under s. Med 13.02 (1v) (a) shall pertain to opioid prescribing.~~

2s. The subject matter of a course under s. Med 13.02 (1x) (a) shall pertain to responsible prescribing of opioids and other controlled substances, ~~with an emphasis on informed consent of all patients on opioid therapy and other controlled substances~~.

3. The provider agrees to monitor the attendance and furnish a certificate of attendance to each participant. The certificate of attendance shall certify successful completion of the course or program.
4. The provider is approved by the board.
5. The course or program content and instructional methodologies are approved by the board.

(c) A separate application shall be submitted for each continuing education course or program approval request.

(d) A course or program sponsor may repeat a previously approved course or program without application, if the subject matter and instructor has not changed.

History: Cr. Register, February, 1977, No. 254, eff. 3-1-77; am. Register, February, 1981, No. 302, eff. 3-1-81; renum. Med 13.03 to be 13.03 (1) and am., cr. (intro.), (2), Register, November, 1995, No. 479, eff. 12-1-95; r. and recr. (1), Register, May, 1997, No. 497, eff. 6-1-97; r. (1) (c), Register, December, 1999, No. 528, eff. 1-1-00; correction in (2) made under s. 13.92 (4) (b) 6., Stats., Register November 2011 No. 671; EmR1631: emerg. cr. (3), eff. 11-10-16; CR 16-070: cr. (3) Register May 2017 No. 737, eff. 6-1-17; CR 18-072: am. (3) (b) 2., cr. (3) (b) 2m. Register July 2019 No. 763, eff. 8-1-19; **CR 21-017: am. (3) (a) (intro.), cr. (3) (b) 2s. Register January 2022 No. 793, eff. 2-1-22.**

Med 13.04 **Physician postgraduate training program; length of service.** The board will accept postgraduate training in a program approved by the board under the provisions of s. Med 1.02 (3), as fulfilling the requirements of this chapter for continuing medical education for physicians. Three consecutive months of such postgraduate training shall be deemed to equal 30 hours of acceptable continuing medical education for the purposes of this chapter.

History: Cr. Register, February, 1977, No. 254, eff. 3-1-77; am. Register, March, 1979, No. 279, eff. 4-1-79; am. Register, May, 1997, No. 497, eff. 6-1-97.

Med 13.05 **Evidence of compliance. (1)** PHYSICIANS. The board will accept as evidence of compliance by physicians with the requirements of this chapter, as original documents or verified copies thereof, any or all or any combination of the following:

(a) Certification by either the providing institution or organization or the American medical association or the American osteopathic association, or components thereof, of attendance at and completion of continuing medical education programs approved under the provisions of s. Med 13.03 (1) (a).

(b) A "Physician's Recognition Award" of the American medical association or a certificate of continuing medical education from the American academy of family physicians awarded not more than 12 months prior to the beginning of the calendar year for which application for registration is being made.

(c) Certification by a chief of service or head of department or director of medical education of the providing facility of appointment to and satisfactory participation in a postgraduate training program approved under the provisions of s. Med 13.04.

(2) RETENTION REQUIREMENT. Evidence of compliance shall be retained by each physician through the biennium for which 30 hours of credit are required for registration.

History: Cr. Register, February, 1977, No. 254, eff. 3-1-77; am. (1) (intro.) and r. and recr. (2), Register, February, 1981, No. 302, eff. 3-1-81; am. (1) (intro.), (a) and (2), cr. (1m), Register, May, 1997, No. 497, eff. 6-1-97; r. (1m), am. (2), Register, December, 1999, No. 528, eff. 1-1-00.

Med 13.06 **Audit.** The board shall conduct a random audit of licensees on a biennial basis for compliance with the continuing education requirement stated in s. Med 13.02 (1). The board may require any physician to submit evidence of compliance with the continuing education requirement to the board during the biennium for which 30 hours of credit are required for registration to audit compliance.

History: Cr. Register, February, 1981, No. 302, eff. 3-1-81; am. Register, May, 1997, No. 497, eff. 6-1-97; am. Register, December, 1999, No. 528, eff. 1-1-00; CR 14-033: am. Register May 2015 No. 713, eff. 6-1-15.

Medical Examining Board
Rule Projects (updated 06/03/22)

Clearinghouse Rule Number	Scope #	Scope Expiration	Code Chapter Affected	Relating clause (description)	Current Stage	Next Step
Not Assigned Yet	012-21	08/08/2023	Med 10	Performance of Physical Examinations (Chaperones and Observers during Physical Examinations)	EIA Comment Period Until 06/13/22	Finalize EIA and Fiscal Estimate
20-053	094-20	01/20/2023	Med 13	Continuing Medical Education (Physician use of Electronic CE Tracking)	Legislative Review After 01/03/2023	Adoption
Not Assigned Yet	035-22	10/25/2024	Med 13	Continuing Medical Education (Controlled Substances Prescribing CE)	Drafting Proposals for Board Review at 06/15/22 Meeting	Board Approval of Preliminary Rule Draft
Not Assigned Yet	Not Assigned Yet	Not Assigned Yet	Med 20	Respiratory Care Practitioner Examinations (RCP Jurisprudence Exam)	Project on hold pending results of spring 2022 test software update	N/A
Not Assigned Yet	044-22	11/23/2024	Med 26	Military Medical Personnel	Scope Ready for Implementation	Drafting