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 (1-4)

B. Approval of Minutes of November 20, 2019 (5-9)

C. Introductions, Announcements and Recognition
   1) Milton Bond, Jr. – Public Member (Replaces: Zondag) – 7/1/2023
   2) Clarence Chou, M.D. – Physician Member (Replaces: Zoeller) – 7/1/2023

D. Conflicts of Interest

E. Administrative Matters
   1) Board, Department and Staff Updates
   2) Appointment of Liaisons and Alternates
   3) Delegation of Authorities
   4) Board Members – Term Expiration Dates
      a. Alaa Abd-Elsayed – 7/1/2020
      b. David A. Bryce – 7/1/2021
      c. Milton Bond, Jr. – 7/1/2023
      d. Mary Jo Capodice – 7/1/2018
      e. Michael Carton – 7/1/2020
      f. Clarence Chou – 7/1/2023
      g. Padmaja Doniparthi – 7/1/2021
      h. Bradley Kudick – 7/1/2020
      i. Lee Ann Lau – 7/1/2020
      j. David Roelke – 7/1/2021
      k. Kenneth Simons – 7/1/2018
      l. Sheldon Wasserman – 7/1/2023
      m. Timothy Westlake – 7/1/2020
   5) Appointments, Reappointments, Confirmations, and Committee, Panel and Liaison Appointments (10-11)
   6) Screening Panel and Examination Panel Appointments
Wis. Stat. § 15.085 (3)(b) – Affiliated Credentialing Boards’ Biannual Meeting with the Medical Examining Board to Consider Matters of Joint Interest

F. Presentation: Request to Address Opioid Prescribing Guidelines – Discussion and Consideration (12-18)

G. Review of Items Requiring Credentialing Liaison Review and Current Board Delegated Authorities – Discussion and Consideration (19-23)

H. Federation of State Medical Boards (FSMB) Matters – Discussion and Consideration
   1) 2020-2025 Strategic Plan (24-36)
   2) Draft Report of the Workgroup on Physician Sexual Conduct (27-65)

I. PDMP Requirements and Information – Discussion and Consideration

J. Legislative and Policy Matters – Discussion and Consideration (66-104)
      a. LRB 0325/1 – Assembly Bill 304 (105-110)
      b. LRB 4287/1 – Assembly Bill 526 (111-114)
      c. LRB 4623/1 – Assembly Bill 520 (115-118)

K. Administrative Rule Matters – Discussion and Consideration
   1) Pending or Possible Rulemaking Projects

L. Controlled Substances Board Report – Timothy Westlake

M. Interstate Medical Licensure Compact Commission (IMLCC) – Report from Wisconsin’s Commissioners (119-120)

N. Newsletter Matters – Discussion and Consideration

O. Screening Panel Report

P. CE Broker – Discussion and Consideration

Q. Future Agenda Items

R. 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

S. 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.).

T. Deliberation on DLSC Matters
   1) Stipulations and Final Decisions and Orders
      a. 19 MED 104 – Douglas E. Rapisarda, M.D. (121-126)
   2) Administrative Warnings
      a. 19 MED 054 – T.J.C. (127-128)
      b. 19 MED 072 – A.M.S. (129-130)
      c. 19 MED 197 – N.D. (131-132)
   3) Case Closing(s)
      b. 17 MED 456 – J.F. (137-147)
      c. 18 MED 052 – S.T.S. (148-150)
      d. 18 MED 086 – B.N.B. (151-160)
      e. 18 MED 404 – G.C. (161-200)
      f. 19 MED 052 – D.C.R. (201-214)

U. 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

V. Open Cases

W. Consulting with Legal Counsel

RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION

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

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

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

ADJOURNMENT

ORAL EXAMINATION OF CANDIDATES FOR LICENSURE
ROOM N207

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

CLOSED SESSION – Reviewing Applications and Conducting Oral Examination of zero (0) (at time of agenda publication) Candidates for Licensure – Dr. Westlake and Dr. Bryce

NEXT DATE: JANUARY 15, 2020

************************************************************************************

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. Interpreters for the hearing impaired provided upon request by contacting the Affirmative Action Officer, 608-266-2112.
MEDICAL EXAMINING BOARD
MEETING MINUTES
NOVEMBER 20, 2019

PRESENT: Alaa Abd-Elsayed, M.D. (arrived at 8:10 a.m.); David Bryce, M.D; Mary Jo Capodice, D.O.; Michael Carton (arrived via Skype at 8:25 a.m.), Padmaja Doniparthi, M.D.; Bradley Kudick; Lee Ann Lau, M.D. (arrived at 8:03 a.m.); David Roelke, M.D.; Kenneth Simons, M.D.; Sheldon Wasserman, M.D.; Timothy Westlake, M.D.

EXCUSED: Robert Zoeller, M.D.

STAFF: Valerie Payne, Executive Director; Debra Sybell, Executive Director; Jameson Whitney, Legal Counsel; Megan Glaeser, Bureau Assistant; and other Department staff

CALL TO ORDER
Kenneth Simons, Chairperson, called the meeting to order at 8:02 a.m. A quorum was confirmed with eight (8) members present.

(Lee Ann Lau arrived at 8:03 a.m.)

ADOPTION OF AGENDA

MOTION: Sheldon Wasserman moved, seconded by David Roelke, to adopt the Agenda as published. Motion carried unanimously.

APPROVAL OF MINUTES OF OCTOBER 16, 2019

MOTION: David Roelke moved, seconded by Mary Jo Capodice, to adopt the Minutes of October 16, 2019 as published. Motion carried unanimously.

(Alaa Abd-Elsayed arrived at 8:10 a.m.)

LEGISLATION AND POLICY MATTERS

Draft Related Issues Regarding LRB 0196/2, Relating to Regulation of Physician Assistants, Creating a Physician Assistant Examining Board, Extending the Time Limit for Emergency Rule Procedures, Providing an Exemption From Emergency Rule Procedures, Granting Rule-Making Authority, and Providing a Penalty

MOTION: Alaa Abd-Elsayed moved, seconded by David Bryce, to delegate Timothy Westlake to draft a letter of unanimous support on behalf of the Board regarding legislative action to extend the PDMP requirements for 5 years. Motion carried unanimously.

(Michael Carton joined via Skype at 8:25 a.m.)

CLOSED SESSION
MOTION: David Roelke moved, seconded by Mary Jo Capodice, 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.). Kenneth Simons, Chairperson, read the language of the motion aloud for the record. The vote of each member was ascertained by voice vote. Roll Call Vote: Alaa Abd-Elsayed - yes; David Bryce - yes; Mary Jo Capodice - yes; Michael Carton - yes; Padmaja Doniparthi - yes; Bradley Kudick - yes; Lee Ann Lau - yes; David Roelke - yes; Kenneth Simons - yes; Sheldon Wasserman - yes; and Timothy Westlake - yes. Motion carried unanimously.

The Board convened into Closed Session at 8:40 a.m.

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

Stipulations, Final Decisions and Orders

18 MED 127 – Craig L. Olson, M.D.

MOTION: Lee Ann Lau moved, seconded by Bradley Kudick, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Craig L. Olson, M.D., DLSC Case Number 18 MED 127. Motion carried.

(Mary Jo Capodice recused herself and left the room for deliberation and voting in the matter concerning Craig L. Olson, M.D., DLSC Case Number 18 MED 127.)

18 MED 458 – Adilakshmi Kaza, M.D.

MOTION: Timothy Westlake moved, seconded by David Bryce, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Adilakshmi Kaza, M.D., DLSC Case Number 18 MED 458. Motion carried unanimously.

18 MED 484 – George W. Petty, M.D.

MOTION: David Roelke moved, seconded by Bradley Kudick, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against George W. Petty, M.D., DLSC Case Number 18 MED 484. Motion carried unanimously.

18 MED 695 – David W. Andrews, P.A.

MOTION: Bradley Kudick moved, seconded by Alaa Abd-Elsayed, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of
disciplinary proceedings against David W. Andrews, P.A., DLSC Case Number 18 MED 695. Motion carried unanimously.

19 MED 001 – Rodney J. Halverson, M.D.

MOTION: Lee Ann Lau moved, seconded by David Roelke, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Rodney J. Halverson, M.D., DLSC Case Number 19 MED 001. Motion carried unanimously.

19 MED 015 – Thomas J. Strick, M.D.

MOTION: Sheldon Wasserman moved, seconded by Padmaja Doniparthi, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Thomas J. Strick, M.D., DLSC Case Number 19 MED 015. Motion carried unanimously.

Administrative Warnings

18 MED 301 – R.M.

MOTION: David Bryce moved, seconded by Sheldon Wasserman, to table the Administrative Warning in the matter of R.M., DLSC Case Number 18 MED 301. Motion carried unanimously.

18 MED 624 – I.A.

MOTION: Bradley Kudick moved, seconded by Lee Ann Lau, to issue an Administrative Warning in the matter of I.A., DLSC Case Number 18 MED 624. Motion carried unanimously.

19 MED 037 – S.M.N.

MOTION: Sheldon Wasserman moved, seconded by David Roelke, to issue an Administrative Warning in the matter of S.M.N., DLSC Case Number 19 MED 037. Motion carried unanimously.

19 MED 131 – L.S.

MOTION: Lee Ann Lau moved, seconded by Mary Jo Capodice, to issue an Administrative Warning in the matter of L.S., DLSC Case Number 19 MED 131. Motion carried unanimously.

19 MED 207 – A.C.C.

MOTION: Bradley Kudick moved, seconded by David Roelke, to issue an Administrative Warning in the matter of A.C.C., DLSC Case Number 19 MED 207. Motion carried unanimously.
**Case Closings**

**MOTION:** David Roelke moved, seconded by David Bryce, to close the following DLSC Cases for the reasons outlined below:
1. 17 MED 373 – M.D. – No Violation
2. 18 MED 078 – L.B.R. – No Violation
3. 18 MED 135 – B.V.O. – Prosecutorial Discretion (P1)
4. 18 MED 140 – D.D. – No Violation
5. 18 MED 410 – M.H.H. – No Violation
6. 18 MED 539 – M.C. – Insufficient Evidence
7. 18 MED 547 – M.F.T. – No Violation

Motion carried unanimously.

**17 MED 051 – A.J.**

**MOTION:** David Roelke moved, seconded by Bradley Kudick, to close DLSC Case Number 17 MED 051, against A.J., for Insufficient Evidence. Motion carried unanimously.

**17 MED 508 – J.M.**

**MOTION:** David Roelke moved, seconded by Lee Ann Lau, to table DLSC Case Number 17 MED 508, against J.M. Motion carried unanimously.

**18 MED 139 – L.S.**

**MOTION:** Lee Ann Lau moved, seconded by David Roelke, to close DLSC Case Number 18 MED 139, against L.S., for No Violation. Motion carried.

*(Kenneth Simons recused himself and left the room for deliberation and voting in the matter concerning L.S., DLSC Case Number 18 MED 139.)*

**18 MED 225 – J.J.E.**

**MOTION:** Bradley Kudick moved, seconded by David Bryce, to close DLSC Case Number 18 MED 225, against J.J.E., for No Violation. Motion carried unanimously.

**18 MED 235 – L.T.**

**MOTION:** Lee Ann Lau moved, seconded by David Roelke, to close DLSC Case Number 18 MED 235, against L.T., for Prosecutorial Discretion (P7). Motion carried.

*(David Bryce recused himself and left the room for deliberation and voting in the matter concerning L.T., DLSC Case Number 18 MED 235.)*

**19 MED 081 – J.H., A.G., G.Z.**

**MOTION:** Timothy Westlake moved, seconded by Alaa Abd-Elsayed, to table DLSC Case Number 19 MED 081, against A.G. Motion carried unanimously.
MOTION: Bradley Kudick moved, seconded by Sheldon Wasserman, to close DLSC Case Number 19 MED 081, against J.H. and G.Z., for No Violation. Motion carried unanimously.

MOTION: Sheldon Wasserman moved, seconded by Lee Ann Lau, to refer Dr. Cenon Buencamino to intake for practice concerns related to DLSC Case Number 19 MED 081. The Board requests to bypass the screening panel. Motion carried unanimously.

19 MED 210 – A.G.

MOTION: David Roelke moved, seconded by Timothy Westlake, to close DLSC Case Number 19 MED 210, against A.G., for No Violation. Motion carried unanimously.

RECONVENE TO OPEN SESSION

MOTION: Bradley Kudick moved, seconded by David Bryce, to reconvene to Open Session. Motion carried unanimously.

The Board reconvened to Open Session at 9:41 a.m.

VOTE ON ITEMS CONSIDERED OR DELIBERATED UPON IN CLOSED SESSION

MOTION: Mary Jo Capodice moved, seconded by Timothy Westlake, 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: David Bryce moved, seconded by David Roelke, to delegate ratification of examination results to DSPS staff and to ratify all licenses and certificates as issued. Motion carried unanimously.

ADJOURNMENT

MOTION: Lee Ann Lau moved, seconded by Sheldon Wasserman, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 9:42 a.m.
# AGENDA REQUEST FORM

<table>
<thead>
<tr>
<th>1) Name and title of person submitting the request:</th>
<th>2) Date when request submitted:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Megan Glaeser, Bureau Assistant</td>
<td>12/11/19</td>
</tr>
</tbody>
</table>

*Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting*

<table>
<thead>
<tr>
<th>3) Name of Board, Committee, Council, Sections:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Examining Board</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4) Meeting Date:</th>
<th>5) Attachments:</th>
<th>6) How should the item be titled on the agenda page?</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/18/19</td>
<td>Yes</td>
<td>Administrative Matters; Appointments, Reappointments, Confirmations, and Committee, Panel and Liaison Appointments</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7) Place Item in:</th>
<th>8) Is an appearance before the Board being scheduled? (If yes, please complete Appearance Request for Non-DSPS Staff)</th>
<th>9) Name of Case Advisor(s), if required:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Session</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10) Describe the issue and action that should be addressed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Chairperson should review and appoint Liaisons and Alternates as appropriate as a result of Dr. Zoeller’s resignation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11) Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Megan Glaeser</td>
</tr>
</tbody>
</table>

**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.
## Appointment of Liaisons and Alternates

<table>
<thead>
<tr>
<th>2019 LIAISON APPOINTMENTS</th>
<th></th>
</tr>
</thead>
</table>
| **Credentialing Liaison(s)** | Padmaja Doniparthi, Robert Zoeller  
Alternate: Lee Ann Lau, Sheldon Wasserman |
| **Office of Education and Examinations Liaison(s)** | David Roelke  
Alternate: David A. Bryce |
| **Continuing Education Liaison(s)** | Lee Ann Lau  
Alternate: Alaa Abd-Elsayed |
| **Monitoring Liaison(s)** | Mary Jo Capodice  
Alternate: Padmaja Doniparthi |
| **Professional Assistance Procedure (PAP) Liaison(s)** | Padmaja Doniparthi  
Alternate: Mary Jo Capodice |
| **Legislative Liaison** | Timothy Westlake |
| **Travel Liaison(s)** | Kenneth Simons  
Alternate: David A. Bryce |
| **Newsletter Liaison(s)** | Bradley Kudick  
Alternate: Michael Carton |
| **Prescription Drug Monitoring Program Liaison(s)** | Timothy Westlake  
Alternate: David Bryce |
| **Website Liaison(s)** | Michael Carton  
Alternate: Lee Ann Lau |
| **Administrative Rules Liaison(s)** | David Roelke  
Alternate: Robert Zoeller |
| **Appointed to Controlled Substances Board as per Wis. Stats. §15.405(5g) (MED)** | Timothy Westlake |
**State of Wisconsin**  
**Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

<table>
<thead>
<tr>
<th>1) Name and title of person submitting the request:</th>
<th>2) Date when request submitted:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valerie Payne, Executive Director on behalf of Chronic Pain Advocates for the State of Wisconsin</td>
<td>Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3) Name of Board, Committee, Council, Sections:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Examining Board</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4) Meeting Date:</th>
<th>5) Attachments:</th>
<th>6) How should the item be titled on the agenda page?</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 18, 2019</td>
<td>☑ Yes</td>
<td>Presentation, Discussion, and Consideration: Request to Address Opioid Prescribing Guidelines</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7) Place Item in:</th>
<th>8) Is an appearance before the Board being scheduled? (If yes, please complete Appearance Request for Non-DSPS Staff)</th>
<th>9) Name of Case Advisor(s), if required:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Open Session</td>
<td>☑ Yes</td>
<td>NA</td>
</tr>
</tbody>
</table>

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

Chronic Pain Advocates for the State of Wisconsin has requested an appearance before the MEB to address what it identifies as problems with the recently revised state opioid guidelines.

<table>
<thead>
<tr>
<th>11) Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of person making this request Date</td>
</tr>
<tr>
<td>Supervisor (if required) Date</td>
</tr>
<tr>
<td>Executive Director signature (indicates approval to add post agenda deadline item to agenda) Date</td>
</tr>
</tbody>
</table>

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.

*Revised 07/2019*
Dear Medical Examining Board:

I am writing on behalf of a national patient advocacy group, Don’t Punish Pain (Rally), and its Wisconsin state chapter who will be holding a rally on Oct 16, the same date as your next meeting. I would like to suggest a meeting agenda to turn back pain medication restrictions.

Today’s pain management practices have been hijacked by policies resembling ideology more than actual science. Like prohibition of 100 years ago, which killed around 10,000 people directly before it was repealed, there are lives at stake here and urgency is required.

We as patients are deeply disturbed with the current trend of pain shaming, pill shaming, forced tapers, restrictive guidelines, one size fits all approaches, MME limits, PDMPs, and patient abandonments. Your recently revised state “opioid” guidelines include all of these things. Also disturbing is the trend to speak of pain as if it is a mental illness, or something that can be easily dismissed or “accepted”.

We do not believe “opioids” is an accurate term. There is a world of difference between illicit fentanyl, heroin, cocaine, meth, and prescription hydrocodone. The media portrays all illicit drug use as prescription drug misuse, by showing pills and pill bottles when discussing heroin deaths. This has led to many misconceptions and stigma toward those of us who need prescription medications to manage intractable (non curative) pain. Neither is long term prescription use a chronic disorder, and the term “chronic opioid therapy” mischaracterizes the treatment as a disease. No one refers to diabetics as “chronic insulin users”. We feel this language is insulting and derogatory and it often appears in the media and in your recent guidelines.

Not only are we being insulted and stigmatized but our health is being jeopardized with decreased access to reliable and effective pain relief. We are also being treated as “hot potatoes” by the medical community who know they may risk their license if they take us on as patients and help us manage our pain. While pain IS the number one reason people seek medical help, we have limited access to help with ANY condition. A recent MI study showed that over 40% of pcps would not take on a new patient if he/she was on long-term pain medication.


Your guidelines are troubling in so many ways. GL #1 seems to imply that doctors are to QUESTION the authenticity of a patient’s report of pain, at least its intensity. I can see no good doctor-patient relationship able to develop or continue in such an atmosphere of distrust. We should be treated with dignity as patients, not suspects.

Your claims that narcotic pain medication is not effective even for acute pain is astounding. Clearly it is healthier for a patient to recover from surgery if their ability to move is not restricted by untreated pain. The claim that these medications do not work long-term is also not accurate as no such studies (past 6 months duration) exist due to control group and ethical problems.


We understand the CDC wrote some guidelines in 2016 and yours seem to be modeled off of that, although we do not know where the MEB came up with 50MME, when the CDC suggested 90MME? The CDC clarified in April 2019 when they wrote the following in the revered ‘New England Journal of Medicine’, ‘Unfortunately, some policies and practices purportedly derived from the guidelines have in fact been inconsistent with, and often go beyond, its
recommendations. A consensus panel has highlighted these inconsistencies, five of which include inflexible application of recommended dosage and duration thresholds"https://www.nejm.org/doi/full/10.1056/NEJMp1904190.

Shortly after that the FDA issued a warning NOT to force taper patients. And never rapidly as this could endanger the patient's life. Your guideline seems only concerned about the life of an unborn child or someone with chest pain. This seems to imply that all other patients can be rapidly tapered with no danger? This is not what the FDA says.

This is not a complete list of the problems we have with the guideline. We are also appalled at the WI DOJ sending threatening letters to 180 practitioners. This is an act of terror that is in effect a practicing of medicine by a law enforcement agency.

We invite you to attend our rally on Oct 16th, from 11am to 1pm, outside your office. We are a grassroots organization that will be protesting the treatment of pain patients nationwide on that day. The few (minority) of us who are able to participate in this rally will be standing up for those (majority) now in too much pain to travel due to the forced tapering of these formerly stable intractable pain patients.

While getting old, sick, and dying are normal things to be expected from life, callous treatment throughout should not be. We should not be subjecting current and future generations to a heartless end of life, where assisted suicide is preferable to extending your life even one more day.

Sincerely, Chronic Pain Advocates for the State of Wisconsin:

Tammy Malik
Dana Weinberger
Jillian Engl
Nancy Schuster-Stoehlker
Theia Lynn Revolt
Good evening Valerie,

I hope this email finds you well. We've narrowed down our selection of handout/reference materials in advance of the December MEB meeting and are so appreciative of the opportunity to preface the presentation and subsequent conversation with these resources.

I have arranged the materials below for convenience. (We expect some members may be familiar with certain items, so it is not quite as bulky as it looks.)


   CDC Guideline authors Drs. Dowell, Haegerich, and Choua issued this commentary following years of concern and amidst reports of harm done to pain patients. We see many of the noted concerns playing out here in the state of Wisconsin and look forward to sharing these with you as specifically applied to the [2019 Wisconsin Opioid Prescribing Guideline](https://www.healthywisconsin.org/wisconsin-opioid-prescribing-guideline).

   Excerpts: "Unfortunately, some policies and practices purportedly derived from the guideline have in fact been inconsistent with, and often go beyond, its recommendations. A consensus panel has highlighted these inconsistencies, which include inflexible application of recommended dosage and duration thresholds and policies that encourage hard limits and abrupt tapering of drug dosages, resulting in sudden opioid discontinuation or dismissal of patients from a physician’s practice. The panel also noted the potential for misapplication of the recommendations to populations outside the scope of the guideline... [and] policies invoking the opioid-prescribing guideline that do not actually reflect its content and nuances can be used to justify actions contrary to the guideline’s intent."

2. **FDA identifies harm reported from sudden discontinuation of opioid pain medicines and requires label changes to guide prescribers on gradual, individualized tapering**, FDA statement issued April 2019

   FDA issued this statement recognizing significant harm to pain patients who have been force-tapered from opioids or abandoned altogether. We are seeing patient abandonment and rampant force-tapering across the state of Wisconsin as is addressed in this statement. (The October 10 HHS [Guide for Appropriate Tapering](https://www.samhsa.gov/behavioral-health/physical-health-treatment-guides) instructional has not changed this.)

3. **Human Rights Watch Report: Not Allowed to be Compassionate**
   December 2018 -- PDF Attached (likely at bottom of email)
This expansive, evidence-based report documents how after-effects of the CDC Guidelines have had an unintended and harmful chilling effect, making doctors fear repercussions for prescribing even to patients with severe chronic pain who have a legitimate medical need for prescription opioids. Based on dozens of interviews with patients, medical professionals, pharmacists, public officials, and health experts, the report describes how policies intended to stem the rise in overdose deaths have also driven harmful cutbacks in opioid prescribing to people who need these medicines.

4. **Safety concerns with the Centers for Disease Control opioid calculator** from December 2017, Journal of Pain Research (Fudin et al)

The authors explore "the controversy regarding the methodology used to develop the CDC opioid prescribing guidelines" including concerns over the groups involved in the formation of the guidelines, the exclusion of opioid therapy studies with observation periods of less than 1 year, and the decision to assign "grade A" to 11 of the Recommendations despite the fact that all 12 Recommendations were based on level 3 or 4 evidence.

5. **Only 1 Percent of People Become Chronic Opioid Users After Hospital Prescriptions for Injuries, Study Shows** Newsweek, November 12 2019

Excerpt: "Prescription pills were involved in almost a quarter of those cases, but it's unclear how many people mixed them with more deadly substances before their overdose. The CDC reports "deaths involving" opioid prescriptions, methadone, heroin and others without accounting for overlap between the categories... A recent Massachusetts study looked at the overlap, reporting that only 1.3% of overdose decedents had an active prescription for every opioid detected in their system. Instead, most used heroin and fentanyl, while nearly a quarter of overdoses studied resulted from a mix of heroin, fentanyl and prescription pills in some combination. Public health experts largely agree that federal efforts to suppress prescription opioid availability have led to more demand for deadlier drugs, in part creating a market for mass quantities of phony pills created by Mexican drug cartels and a meth resurgence in New England." We note that Wisconsin is seeing a meth resurgence as well: The Wisconsin State Crime Laboratory handled 1,452 meth cases in 2018 — an increase of greater than 450% since 2008.

6. **Promoting Pain Relief and Preventing Abuse of Pain Medications: A Critical Balancing Act**

A 1-page joint statement from 21 health organizations and the DEA that recognizes pain is undertreated and that for many pain patients, opioid analgesics "when used as recommended by established pain management guidelines — are the most effective way to treat their pain, and often the only treatment option that provides significant relief."

7. **Protesters voice concerns about lack of pain medication**- WMTV news coverage of the October 2019 Madison, Wisconsin Don't Punish Pain Rally

8. 'I'm not an addict, I'm in pain': Rally protests new regulations on painkillers - Post-Crescent news coverage of the September 2018 Appleton, Wisconsin Don't Punish Pain Rally

9. **Resolution 235: Inappropriate use of the CDC Guidelines for Prescribing Opioids**

Passed by the AMA House of Delegates on November 13, 2018

A one-page resolution by the American Medical Association that advises "no entity should use MME as anything more than guidance" and declares "some patients with acute or chronic pain can benefit from taking opioid pain medication at doses greater than generally recommended in the CDC Guideline for Prescribing Opioids for Chronic Pain and that such care may be medically necessary and appropriate/"

10. **FDA Response to PROP Petition**

September 2013 -- Attached
Excerpts:

- "It is FDA's view that a patient without cancer, like a patient with cancer, may suffer from chronic pain, and PROP has not provided scientific support for why labeling should recommend different treatment for such patients. In addition, FDA knows of no physiological or pharmacological basis upon which to differentiate the treatment of chronic pain in a cancer setting or patient from the treatment of chronic pain in the absence of cancer, and comments to the Petition docket reflect similar concerns. FDA therefore declines to make a distinction between cancer and non-cancer chronic pain in opioid labeling."

- "FDA agrees that adverse events and substance cause of opioids occur at high doses - but adverse events can also occur at doses less than 100 mg MED. FDA also acknowledges that the available data do suggest a relationship between increasing opioid doses and risk of certain adverse effects. However the available information does not demonstrate that the relationship is necessarily a causal one... the scientific literature does not support establishing a maximum recommended daily dose of 100 MED. Further, creating a maximum dose of 100 mg MED, or another dose ceiling, could imply a superior opioid safety profile under that set threshold, when there are no data to support such a conclusion."

- "[Medical] Professional societies also expressed concern that the labeling changes requested by PROP were not supported by scientific evidence, and that a "one-size-fits-all" approach to maximum dose or duration of treatment would be problematic and inconsistent with the need for individualized treatment and the variability among patient responses to opioids."

Thank you kindly Valerie, and please let me know if you have any questions. We are looking forward to the December meeting!

Best,
Jillian Engl
on behalf of Chronic Pain Advocates of Wisconsin
### State of Wisconsin
#### Department of Safety & Professional Services

#### AGENDA REQUEST FORM

<table>
<thead>
<tr>
<th>1) Name and Title of Person Submitting the Request:</th>
<th>2) Date When Request Submitted:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jameson Whitney, Board Counsel</td>
<td>12/5/19</td>
</tr>
</tbody>
</table>

Items will be considered late if submitted after 4:30 p.m. and less than:
- 8 work days before the meeting for Medical Board
- 8 work days before the meeting for all others

<table>
<thead>
<tr>
<th>3) Name of Board, Committee, Council, Sections:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Examining Board</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4) Meeting Date:</th>
<th>5) Attachments:</th>
<th>6) How should the item be titled on the agenda page?</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/18/2019</td>
<td>☒ Yes</td>
<td>Current year’s delegations—for the Board’s review</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7) Place Item in:</th>
<th>8) Is an appearance before the Board being scheduled?</th>
<th>9) Name of Case Advisor(s), if required:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Open Session</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10) Describe the issue and action that should be addressed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Board asked to see the delegations they approved at the beginning of the year, for review and discussion.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11) Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jameson R. Whitney</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of person making this request</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supervisor (if required)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Executive Director signature (indicates approval to add post agenda deadline item to agenda)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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.
Delegation of Authorities

Document Signature Delegations

MOTION: Lee Ann Lau moved, seconded by Mary Jo Capodice, to delegate authority to the Chairperson (or in absence of the Chairperson, the highest-ranking officer or longest serving board member in that succession) to sign documents on behalf of the Board in order to carry out its duties. Motion carried unanimously.

MOTION: Bradley Kudick moved, seconded by Robert Zoeller, in order to carry out duties of the Board, the Chairperson, chief presiding officer, or longest serving board member, has the ability to delegate signature authority for purposes of facilitating the completion of assignments during or between meetings. The members of the Board hereby delegate to the Executive Director or DPD Division Administrator, the authority to sign on behalf of a board member as necessary. Motion carried unanimously.

Delegated Authority for Urgent Matters

MOTION: Padmaja Doniparthi moved, seconded by David Bryce, that in order to facilitate the completion of urgent matters between meetings, the Board delegates its authority to the Chairperson (or, in the absence of the Chairperson, the highest-ranking officer or longest serving board member in that succession), to appoint liaisons to the Department to act in urgent matters. Motion carried unanimously.

Monitoring Delegations

MOTION: Robert Zoeller moved, seconded by Rodney Erickson, to adopt the “Roles and Authorities Delegated to the Monitoring Liaison and Department Monitor” as presented. Motion carried unanimously.

Credentialing Authority Delegations

Delegation of Authority to Credentialing Liaison – Exempting Denial Decisions to Full Board

MOTION: Mary Jo Capodice moved, seconded by Lee Ann Lau, to delegate authority to the Credentialing Liaison(s) to serve as a liaison between DSPS and the Board and to act on behalf of the Board in regard to credentialing applications or questions presented to them except that potential denial decisions shall be referred to the full Board for final determination. Motion carried unanimously.
Delegation of Authority to DSPS When Credentialing Criteria is Met

MOTION: Robert Zoeller moved, seconded by Bradley Kudick, to delegate credentialing authority to DSPS to act upon applications that meet all credentialing statutory and regulatory requirements without Board or Board liaison review. Motion carried unanimously.

MOTION: Lee Ann Lau moved, seconded by David Bryce, to delegate authority to the DSPS attorneys to review and approve ordinance violations which are not substantially related to the practice of medicine, limited to:
1. Littering
2. Loitering
3. Up to two (2) Underage Drinking
4. One (1) OWI two or more years prior to application
5. Trespassing
6. Disturbing the Peace
Motion carried unanimously.

MOTION: Timothy Westlake moved, seconded by Rodney Erickson, to delegate authority to DSPS attorneys to review and approve conviction reviews for Medicine & Surgery (Physicians) applications which have previously been approved for a full Resident Educational License (REL) license after a criminal background check and there have been no new violations or convictions since the previous license approval. Motion carried unanimously.

Council Delegation Motion

MOTION: Timothy Westlake moved, seconded by Rodney Erickson, to delegate to the Board’s Councils and/or its liaison(s), the authority to review applications and conduct examinations of candidates for licensure and to make recommendations regarding the licensure of applicants based upon the application reviews and examinations. Recommended credential denials should be considered by the Medical Examining Board. This delegation motion is not intended to be exhaustive of the Councils’ advisory authority. Motion carried unanimously.

Delegated Authority for Application Denial Reviews

MOTION: Padmaja Doniparthi moved, seconded by Lee Ann Lau, that the Department’s Attorney Supervisors, DLSC Administrator, or their designee are authorized to serve as the Board’s designee for purposes of reviewing and acting on requests for hearing as a result of a denial of a credential. Motion carried unanimously.
Education, Continuing Education and/or Examination Delegation(s)

**MOTION:** Timothy Westlake moved, seconded by David Bryce, to delegate authority to the Education, Continuing Education and/or Examination Liaison(s) to address all issues related to education, continuing education, and examinations. Motion carried unanimously.

Authorization for DSPS to Provide Board Member Contact Information to National Regulatory Related Bodies

**MOTION:** Robert Zoeller moved, seconded by Bradley Kudick, to authorize DSPS staff to provide national regulatory related bodies with all Board member contact information that DSPS retains on file. Motion carried unanimously.

Optional Renewal Notice Insert Delegation

**MOTION:** Bradley Kudick moved, seconded by Timothy Westlake to designate the Chair (or, in the absence of the Chairperson, the highest-ranking officer or longest serving board member in that succession) to provide a brief statement or link relating to board-related business within the license renewal notice at the Board’s or Board designee’s request. Motion carried unanimously.

Legislative Liaison Delegation

**MOTION:** Robert Zoeller moved, seconded by Lee Ann Lau, to delegate authority to the Legislative Liaison to speak on behalf of the Board regarding legislative matters. Motion carried unanimously.

Travel Delegation

**MOTION:** Mary Jo Capodice moved, seconded by Lee Ann Lau, to delegate authority to the Travel Liaison(s) to approve any board member travel. Motion carried unanimously.

Delegation of Authority to Assign and Schedule Members to Screening Panels and Oral Examinations

**MOTION:** Lee Ann Lau moved, seconded by Mary Jo Capodice, to delegate to Department staff the assignment and scheduling of screening panel and oral examination panel members. Motion carried unanimously.

Prescreening Delegation
MOTION: Lee Ann Lau moved, seconded by Padmaja Donaparthi, to delegate to DLSC staff, the authority to prescreen complaints for the purpose of reviewing submitted continuing medical education (CME) materials and to determine if CME requirements are met. If CME requirements are met, then DLSC staff should remove such CME documentation from the screening materials prior to the screening panel meeting. If the submitted documentation does not clearly establish that CME requirements are met, such documentation shall be forwarded to the screening panel for review. Motion carried unanimously.

Appointments to the Respiratory Care Practitioners Examining Council

MOTION: Bradley Kudick moved, seconded by Lee Ann Lau, to appoint Chris R. Becker to the Respiratory Care Practitioners Examining Council as a Respiratory Care Practitioner Member as of 7/1/2019 for a term to expire on July 1, 2022. Motion carried unanimously.

MOTION: David Roelke moved, seconded by Bradley Kudick, to reappoint Lynn Waldera to the Respiratory Care Practitioners Examining Council as a Respiratory Care Practitioner Member for a term to expire on July 1, 2020. Motion carried unanimously
State of Wisconsin  
Department of Safety & Professional Services

AGENDA REQUEST FORM

1) Name and title of person submitting the request:  
Valerie Payne, Executive Director, on behalf of Kenneth Simons

2) Date when request submitted:  
12/11/19

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: 12/18/19

5) Attachments:  
☒ Yes  
☐ No

6) How should the item be titled on the agenda page?  
Federation of State Medical Boards (FSMB) Matters – Discussion and Consideration

1) Proposed FSMB 2020-2025 Strategic Plan

2) FSMB’s Workgroup on Physician Sexual Misconduct Draft Report

7) Place Item in:  
☒ Open Session  
☐ Closed Session

8) Is an appearance before the Board being scheduled? (If yes, please complete Appearance Request for Non-DPS Staff)  
☐ Yes  
☒ No

9) Name of Case Advisor(s), if required:

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

Discussion of FSMB Matters

1) Proposed FSMB 2020-2025 Strategic Plan – comments to the draft plan are due by January 24, 2020.

2) FSMB’s Workgroup on Physician Sexual Misconduct Draft Report – comments to the draft report are due by Friday, January 10, 2020.

11) Authorization

Valerie Payne  
12/11/19

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.

Revised 07/2019
Dear Member Board Presidents/Chairs and Executive Directors/Secretaries,

As you may know, the FSMB periodically evaluates and updates its Strategic Plan, convening a special committee to accomplish this task. The 2019-2020 Special Committee on Strategic Planning, appointed by FSMB Chair Scott A. Steingard, DO has completed its review of the current FSMB Strategic Plan, last updated in 2015.

The Committee was asked to identify possible areas of modification of the current Strategic Plan and to develop new strategic-planning recommendations, taking into account emerging trends and changes in the environment for medical regulation over the last five years.

The Committee’s Report, in draft form, can be accessed by clicking the STRATEGIC PLAN REPORT.

During the course of its work, including a full-day meeting at FSMB headquarters in Euless, Texas, and a later teleconference, the Committee discussed the current medical regulatory environment in the United States and internationally, highlighting key trends and identifying challenges and opportunities for the FSMB.

In preparation for these discussions, the Committee reviewed a variety of information resources, including results of strategic planning surveys of state medical board leaders and other stakeholders, summaries of strategic-visioning exercises conducted by the FSMB over the last two years and other FSMB reports and data. The Committee also carefully reviewed the FSMB’s various recent major initiatives and operational priorities.

The proposed Strategic Plan for 2020-2025, included here with the Committee’s draft report on page 11, will be considered by the House of Delegates at its April meeting in San Diego, California.

Any comments or input on the draft Plan should be sent by email to pmccarty@fsmb.org no later than January 24, 2020.

Sincerely,

Humayun “Hank” Chaudhry, D.O., MACP
President and CEO

Federation of State Medical Boards
400 Fuller Wiser Road  |  Suite 300  |  Euless, Texas  76039
817-868-4044 direct  |  817-868-4144 fax
hchaudhry@fsmb.org  |  www.fsmb.org
FEDERATION OF STATE MEDICAL BOARDS
SPECIAL COMMITTEE ON STRATEGIC PLANNING

Report on FSMB Strategic Plan Recommendations
2020-2025

FSMB Strategic Planning Committee Summary and Draft Plan

The FSMB Special Committee on Strategic Planning met August 14-15, 2019 in Euless, Texas, and again by videoconference on November 22, to review the FSMB’s current strategic plan (see page 6) and make recommendations for a new plan, to be implemented in May 2020 (see page 11).

In preparation for its discussions, the Committee reviewed a variety of documents and information resources, including the:
- 2015 FSMB Board Report on Strategic Planning
- 2019 FSMB Strategic Planning Surveys, gauging opinions of state medical boards leaders and other stakeholders
- Summaries of strategic-visioning exercises conducted by the FSMB Board of Directors and FSMB staff in 2018 and 2019

At its August meeting, the Committee engaged in large-group and small-group discussions, identifying environmental factors, challenges and opportunities in health care and medical regulation that could impact the next strategic plan.

After a comprehensive review of the current strategic plan, the Committee has concluded that the plan remains fundamentally sound in that it continues to focus on core values and relevant strategic imperatives. The Committee recommended slight adjustments, however, to align elements of the plan more closely with emerging trends and new issues of importance to state medical boards.

The recommended changes are intended to respond to:
- The need for the FSMB to provide strong leadership in an era of accelerating change in the health care sector, and the importance of adaptability and the ability to manage change in this new era.
- The continuing rise of data-use and technology – including telemedicine and artificial intelligence – as significant factors in health care.
- The particular need to maintain vigilance, safety and oversight in the midst of new team-based care models and a blurring scope-of-practice environment.
- The continuing need for service and support from the FSMB for its member boards – which will rely increasingly on the FSMB to serve as a hub and facilitator at a time when the sharing of data, resources and best practices requires a strongly interconnected medical regulatory community.
- **Increasing public empowerment** – bringing with it the need for state medical boards to be responsive to the clear preferences of consumers/patients, who put a priority on efficiency, speed and transparency when dealing with institutions.
- Trends toward *corporatization, commoditization and consolidation* in health care, which may have potentially profound impacts on medical regulation.
- The rise of *legislative/political incursions into medicine* and *de-regulatory forces* in the United States, including developments since the Supreme Court’s *North Carolina Board of Dental Examiners v. Federal Trade Commission* decision.
- Changing trends in the nation’s **workforce of physicians, physician assistants and other health care professionals**, and in the ways **medical education** is delivered.

The Committee’s discussions and conclusions underscore the need for strong leadership and wise policies from the medical regulatory community to help guide the next generation of medicine in the United States through a period of historic change.

**SUMMARY OF DISCUSSIONS**

**Environmental Factors**

The Committee discussed a variety of environmental factors impacting medical regulation that should be taken into account in developing a new strategic plan. These included:

**The rapid advance of technology in health care.** Technological innovations – particularly the use of telemedicine and the growth of artificial intelligence – are changing the way health care is delivered. While technology is clearly impacting medicine, it is also impacting the process of medical regulation: As an example, the digitization of records and use of block-chain technology will impact standard oversight processes, such as credentialing and credentials verification.

**The role and importance of data.** “Big Data” is a powerful factor across all sectors, as technology improves our ability to gather, analyze and share large amounts of information. The volume of health-care-related data – and new technology platforms that widen its potential use – continue to expand. This ability brings both opportunities and challenges, as issues of privacy, data ownership and systems-compatibility must be managed in a complex, dynamic environment.

**Consolidation and corporatization in health care delivery.** The rate of merger among hospitals and physician group-practices continues to increase, with a variety of impacts. More and more physicians are now working as employees of large health systems – which maintain their own internal physician oversight processes and practice standards, independent of the regulatory system. Additionally, large retailers – such as CVS and Walmart – are increasing their reach into the health care sector, with expanded health care delivery services offered through retail clinics. Google, Apple and other huge technology-based corporations are also expanding their role in health care – and changing consumer behavior and expectations in the process. The influence of these large corporate entities on the health system overall will continue to rise.
“Commoditization” in medical practice. The confluence of technological innovation and corporate growth and influence has led to an environment in which health care outcomes, quality, price and access are increasingly driven by the competitive marketplace. As a result, medicine becomes more vulnerable to de-professionalization, and the patient-physician relationship becomes more vulnerable to de-personalization. As concerns about the impacts of commoditization grow, there is a perception that the overall influence of the medical community – an important bulwark for patient safety and quality in health care – is being undercut as a result of these trends.

The continued rise of consumer empowerment. Thanks largely to the growth of the Internet over several decades, consumers continue to wield greater influence in health care – ranging from increased awareness of medical options to self-diagnosis and heightened expectations for outcomes, cost and care delivery. The development of household and wearable medical devices and greater access to data have led patients to be given a larger role as partners in the health care team. Telemedicine, the growth of retail clinics and other fast, relatively inexpensive models of health care delivery are increasing the expectations of consumers – who don’t want impediments and are less concerned about traditional titles, roles and scope of practice of those who provide their care.

Blurring of lines and traditional roles in health care. In the new team-based health care delivery environment, traditional scope-of-practice boundaries are beginning to shift – particularly in terms of the role of mid-level providers. Physician assistants and other health professionals continue to play a more prominent role in this environment, and the use of artificial intelligence and other technologies is accelerating new scope-of-practice trends.

Physician workforce changes. Demographic shifts indicate that physician shortages in key medical specialties – including primary care – will grow, creating access-to-care issues, particularly in rural areas of the United States. Additionally, the physician workforce is aging and some physicians are working at older ages than previous generations.

Issues in medical education. As technology continues to reshape medical practice, there is a growing need to re-think longstanding approaches in medical education. At the same time, the enormous cost of medical education – including debt-burdens of medical students – is raising concerns and impacting the distribution of new physicians across medical specialties, further contributing to workforce and access-to-care issues.

Physician wellbeing. Concerns about stress-related health issues in the medical workforce have risen in recent years. There is growing evidence that the wellbeing of physicians has significant impact on the quality of health care delivery and issues in medical regulation.

Challenges

Anti-occupational-licensing efforts and a culture of deregulation. In the wake of the Supreme Court’s North Carolina State Board of Dental Examiners v. Federal Trade Commission decision, organized efforts are increasing nationally to scale back on occupational-licensing requirements.
In addition, a culture of deregulation at both state and federal levels has noticeably grown in recent years – with what some perceive as legislative incursions or overreach into the practice of medicine. These trends put new pressures on boards’ ability to conduct regulatory oversight.

Inefficiency of systems in a team-based, consumer-driven health care environment. With blurring lines in the scope of medical practice, professional regulators must be well-coordinated across sectors – but the current lack of systems integration and aligned policies make that a challenge. The issue is exacerbated by the demands of increasingly empowered consumers – and health care professionals – who have little tolerance for inefficiencies in systems. Of particular concern to boards is how to transition from legacy systems in an environment that requires nimbleness and speed.

Questions of accountability and responsibility in regulation. Rapid changes in health care delivery – including the rise of telemedicine, the use of artificial intelligence and an increase in team-based care models – have created new “grey areas” and challenges in determining accountability and responsibility in medical decision-making and care outcomes.

Quality control and maintenance of privacy in a data-rich environment. The ubiquity of data, the proliferation of entry-points for its collection, and the ease with which it can be shared raise new questions for boards regarding its management – including security, privacy and quality.

Opportunities

Leadership. In an era of great change and a high level of uncertainty about the future, the FSMB has an opportunity to play a strong leadership role. The health care system is experiencing “pendulum swings” – and institutions can earn support and trust in this environment by helping to provide stability to their stakeholders. By helping state boards navigate change – and helping build the public’s trust in boards at the same time – the FSMB can establish its value.

Technology and data. The growing availability and importance of technology and data provides a unique opportunity for the FSMB, which in recent years has expanded its data capabilities – including infrastructure investments and a transition to digital platforms. The FSMB is positioned to serve as an information-hub, convener and facilitator as the regulatory community enters a new era of technology and data processing. The growing reality within medicine is that telemedicine, artificial intelligence and other modalities are here and have enormous potential but must be shaped by wise policy.

Education for boards and licensees. In the current health care environment, there is a strong need for ongoing educational opportunities for state medical boards – as well as their licensees. This is particularly important, given the relatively high turnover-rate in the state medical board community: Surveys show that 40% of stakeholders within the Federation have worked in medical regulation for less than five years. By focusing on educating its member boards about emerging trends and best practices and helping them provide targeted continuing professional education for their licensees, the FSMB can help ensure stability amid change.
Communications and advocacy. With the pace of change faced by the health care community, the need for close communication between institutions and their stakeholder audiences – and strong advocacy on key issues – has never been greater. In this environment, the FSMB has the opportunity to deliver value by keeping boards informed, helping raise public awareness of the work they do, and coordinating advocacy on their behalf. This is particularly important in an era when many boards face tight budgets and lean staffing.
CURRENT FSMB STRATEGIC PLAN, 2015-2020

About the FSMB

The Federation of State Medical Boards represents the 70 state-medical and osteopathic regulatory boards – commonly referred to as state medical boards – within the United States, its territories and the District of Columbia. It supports its member boards as they fulfill their mandate of protecting the public’s health, safety and welfare through the proper licensing, disciplining, and regulation of physicians and, in most jurisdictions, other health care professionals.

Vision

The FSMB is an innovative leader, helping state medical boards shape the future of medical regulation by protecting the public and promoting quality health care.

Mission

The FSMB serves as the voice for state medical boards, supporting them through education, assessment, research and advocacy while providing services and initiatives that promote patient safety, quality health care and regulatory best practices.

Strategic Goals

- **State Medical Board Support**: Serve state medical boards by promoting best practices and providing policies, advocacy, and other resources that add to their effectiveness.

- **Advocacy and Policy Leadership**: Strengthen the viability of state-based medical regulation in a changing, globally-connected health care environment.

- **Collaboration**: Strengthen participation and engagement among state medical boards and expand collaborative relationships with national and international organizations.

- **Education**: Provide educational tools and resources that enhance the quality of medical regulation and raise public awareness of the vital role of state medical boards.

- **Data and Research Services**: Expand the FSMB’s data-sharing and research capabilities while providing valuable information to state medical boards, the public and other stakeholders.

- **Organizational Strength and Excellence**: Enhance the FSMB’s organizational vitality and adaptability in an environment of change and strengthen its financial resources in support of its mission.
PROPOSED FSMB STRATEGIC PLAN, 2020-2025 (RECOMMENDATIONS)

Changes to each of the sections of the current Strategic Plan that have been suggested are noted below.

1. “ABOUT THE FSMB” Statement

Current Statement – no recommended changes

The Federation of State Medical Boards represents the 70 state-medical and osteopathic regulatory boards -- commonly referred to as state medical boards -- within the United States, its territories and the District of Columbia. It supports its member boards as they fulfill their mandate of protecting the public’s health, safety and welfare through the proper licensing, disciplining, and regulation of physicians and, in most jurisdictions, other health care professionals.

2. VISION

Current Vision

The FSMB is an innovative leader, helping state medical boards shape the future of medical regulation by protecting the public and promoting quality health care.

Recommendations for change:

• Replace “helping state medical boards” with “supports state medical boards”
• Update the language slightly to better articulate the FSMB’s role of working as an innovative partner as it meets the needs of state medical boards

Proposed Revised Vision

The FSMB supports state medical boards as they protect the public and promote quality health care, partnering and innovating with them to shape the future of medical regulation.

3. MISSION

Current Mission

The FSMB serves as the voice for state medical boards, supporting them through education, assessment, research and advocacy while providing services and initiatives that promote patient safety, quality health care and regulatory best practices.

Recommendations for change:

• Delete “the voice” and replace with “a national voice”
• Add “data”
Proposed Revised Mission

The FSMB serves as a national voice for state medical boards, supporting them through education, assessment, data, research and advocacy while providing services and initiatives that promote patient safety, quality health care and regulatory best practices.

4. STRATEGIC GOALS

Current Goal 1 – no recommended changes

State Medical Board Support: Serve state medical boards by promoting best practices and providing policies, advocacy, and other resources that add to their effectiveness.

Current Goal 2

Advocacy and Policy Leadership: Strengthen the viability of state-based medical regulation in a changing, globally-connected health care environment.

Recommendations for change:
• Replace “viability” with “impact”
• Change “state-based medical regulation” to “state medical regulation”
• Delete “globally” and replace “changing” with “dynamic, interconnected”

Proposed Revised Goal 2

Advocacy and Policy Leadership: Strengthen the impact of state medical regulation in a dynamic, interconnected health care environment.

Current Goal 3

• Collaboration: Strengthen participation and engagement among state medical boards and expand collaborative relationships with national and international organizations.

Recommendations for change:
• Add “government entities” to help clarify that collaboration is sought with both private-sector and public-sector partners
• Include “state” in addition to “national” and “international”
• Replace “strengthen” with “build” to reduce the repetition of the word “strengthen” in the strategic plan goals

Proposed Revised Goal 3

Collaboration: Build participation and engagement among state medical boards and expand collaborative relationships with state, national and international organizations and government entities.
Current Goal 4

Education: Provide educational tools and resources that enhance the quality of medical regulation and raise public awareness of the vital role of state medical boards.

Recommendations for change:
• Add “Communications” to the goal’s title
• Move the phrase “Raise public awareness” to the beginning of the goal’s description
• Add the word “effectiveness”

Proposed Revised Goal 4

Communications and Education: Raise public awareness of the vital role of state medical boards while providing educational tools and resources that enhance the quality and effectiveness of medical regulation.

Current Goal 5

Data and Research Services: Expand the FSMB’s data-sharing and research capabilities while providing valuable information to state medical boards, the public and other stakeholders.

Recommendations for change:
• Add “Technology” to the goal’s title; collapse “Research Services” under the heading “Data”
• Add “Provide leadership in the use of emerging health care technologies”
• Change “data-sharing and research capabilities” to “data and research capabilities”
• Change “while providing” to “sharing”; streamline verbiage to keep goal consistent in length with the other goals

Proposed Revised Goal 5

Technology and Data: Provide leadership in the use of emerging health care technology impacting medical regulation and expand the FSMB’s data and research capabilities, sharing valuable information with stakeholders.

Current Goal 6

Strength and Excellence: Enhance the FSMB’s organizational vitality and adaptability in an environment of change and strengthen its financial resources in support of its mission.

Recommendations for change:
• Remove “financial”
• Replace “vitality and adaptability” with “efficiency, effectiveness and adaptability”
Proposed Revised Goal 6

Organizational Strength and Excellence: Enhance the FSMB’s organizational efficiency, effectiveness and adaptability in an environment of change and strengthen its resources in support of its mission.
PROPOSED FSMB STRATEGIC PLAN, 2020-2025 (FOR APPROVAL)

About the FSMB

The Federation of State Medical Boards represents the 70 state-medical and osteopathic regulatory boards – commonly referred to as state medical boards – within the United States, its territories and the District of Columbia. It supports its member boards as they fulfill their mandate of protecting the public’s health, safety and welfare through the proper licensing, disciplining, and regulation of physicians and, in most jurisdictions, other health care professionals.

Vision

The FSMB supports state medical boards as they protect the public and promote quality health care, partnering and innovating with them to shape the future of medical regulation.

Mission Statement

The FSMB serves as a national voice for state medical boards, supporting them through education, assessment, data, research and advocacy while providing services and initiatives that promote patient safety, quality health care and regulatory best practices.

Strategic Goals

- **State Medical Board Support**: Serve state medical boards by promoting best practices and providing policies, advocacy, and other resources that add to their effectiveness.

- **Advocacy and Policy Leadership**: Strengthen the impact of state medical regulation in a dynamic, interconnected health care environment.

- **Collaboration**: Build participation and engagement among state medical boards and expand collaborative relationships with state, national and international organizations and government entities.

- **Communications and Education**: Raise public awareness of the vital role of state medical boards while providing educational tools and resources that enhance the quality and effectiveness of medical regulation.

- **Technology and Data**: Provide leadership in the use of emerging health care technology impacting medical regulation and expand the FSMB’s data and research capabilities, sharing valuable information with stakeholders.

- **Organizational Strength and Excellence**: Enhance the FSMB’s organizational efficiency, effectiveness and adaptability in an environment of change and strengthen its resources in support of its mission.
Dear Board Chairs/Presidents and Executive Directors,

The FSMB’s Workgroup on Physician Sexual Misconduct has authored a draft report for which it is seeking your comment and feedback.

The Committee’s charge involved:
1) Collecting and reviewing available disciplinary data, including incidence and spectrum of severity of behaviors and sanctions, related to sexual misconduct;
2) Identifying and evaluating barriers to reporting sexual misconduct to state medical boards;
3) Evaluating the impact of state medical board public outreach on reporting;
4) Reviewing the FSMB’s 2006 policy statement, Addressing Sexual Boundaries: Guidelines for State Medical Boards, and revising, amending or replacing it, as appropriate; and
5) Assessing the prevalence of sexual boundary/harassment training in undergraduate and graduate medical education and developing recommendations and/or resources to address gaps.

The Workgroup is chaired by Patricia A. King, MD, PhD, and members include Michael Baron, MD, Kevin Bohnenblust, JD, Rebecca Brendel, MD, JD, Catherine Caldicott, MD, Elliott Crigger, PhD, Katherine Fisher, DO, Vikisha Fripp, MD, Maroulla Gleaton, MD, Alexander Gross, MD, Teresa Hubka, DO, Venkata Jonnalagadda, MD, Anne Lawler, JD, Fleur-Ange Lefebvre, PhD, Jean Rexford, and Michael S. Schottenstein, MD. Participating as ex officio members were Scott A. Steingard, DO, Cheryl Walker-McGill MD, MBA, and Humayun J. Chaudhry, DO.

Please Click Here to Access the Draft Report

Please e-mail comments to Mark Staz, Management Consultant, Regulatory Policy, at mstaz@fsmb.org by Friday, January 10, 2020. Your comments are critical to ensuring that the final document accurately represents the views of the FSMB’s member boards. Once the comment period is closed, the Workgroup will consider the feedback received and make revisions, as appropriate. The final policy document will then be presented to the FSMB House of Delegates for consideration in May 2020 at its Annual Meeting.

Thank you in advance for taking time to respond to this call for comments. We look forward to receiving your responses.

Mark Staz, MA
Management Consultant, Regulatory Policy

Federation of State Medical Boards
400 Fuller Wiser Road  |  Suite 300  |  Euless, TX 76039
613-986-6275 direct  |  817-868-4198 fax
mstaz@fsmb.org  |  www.fsmb.org

ATTENTION: This email may contain confidential and/or privileged material for the sole use of the intended recipient. Any review or distribution by others is strictly prohibited. If you have received this email in error, please immediately notify the sender, and destroy all copies of the original message.
Report of the FSMB Workgroup on Physician Sexual Misconduct

DRAFT

Section 1: Introduction and Workgroup Charge

The relationship between a physician and patient is inherently imbalanced. The knowledge, skills and training statutorily required of all physicians puts them in a position of power in relation to the patient. The patient, in turn, often enters the therapeutic relationship from a position of vulnerability due to illness, suffering, and a need to divulge deeply personal information and subject themselves to intimate physical examination. This vulnerability is further heightened in light of the patient’s trust in their physician, who has been granted the power to deliver care, prescribe needed treatment and refer for appropriate specialty consultation.

These characteristics of the physician-patient relationship are critical to assuring mutual trust between physicians and patients to enable the delivery of quality health care. When there is a violation of that relationship through sexual misconduct, such behavior and actions can have a profound, enduring and traumatic impact on the individual being exploited, their family, the public at large, and the medical profession as a whole. Properly and effectively addressing sexual misconduct by physicians through sensible standards and expectations of professionalism, including preventive education, as well as through meaningful disciplinary action and law enforcement when required, is therefore a paradigmatic expression of self-regulation and its more modern iteration, shared regulation.

In May of 2017, Patricia King, M.D., PhD., Chair at the time of the Federation of State Medical Boards (FSMB), created and led a Workgroup on Physician Sexual Misconduct (hereafter referred to as “the Workgroup”), and charged its members with 1) collecting and reviewing available disciplinary data, including incidence and spectrum of severity of behaviors and sanctions, related to sexual misconduct; 2) identifying and evaluating barriers to reporting sexual misconduct to state medical boards, including, but not limited to, the impact of state confidentiality laws, state administrative codes and procedures, investigative procedures, and cooperation with law enforcement on the reporting and prosecution/adjudication of sexual misconduct; 3) evaluating the impact of state medical board public outreach on reporting; 4) reviewing the FSMB’s 2006 policy statement, Addressing Sexual Boundaries: Guidelines for State Medical Boards, and revising, amending or replacing it, as appropriate; and 5) assessing the prevalence of sexual boundary/harassment training in undergraduate and graduate medical education and developing recommendations and/or resources to address gaps.

In carrying out its charge, the Workgroup adopted a broad lens with which to scrutinize not only the current practices of state medical boards and other professional regulatory authorities in the United States and abroad, but also elements of professional culture within American medicine, including notions of professionalism, expectations related to reporting instances of misconduct or impropriety, evolving public expectations of the medical profession, and the impact of trauma on survivors of sexual misconduct. In analyzing these issues, the Workgroup benefited tremendously from discussions with several of the FSMB’s partner organizations and stakeholders that also have a role in addressing the issue of physician sexual misconduct. The
Workgroup extends its thanks, in particular, to the American Association of Colleges of Osteopathic Medicine (AACOM), Association of American Medical Colleges (AAMC), Student Osteopathic Medical Association (SOMA), Australian Health Practitioner Regulation Agency (AHPRA), American Medical Association (AMA), American Medical Women’s Association (AMWA), American Osteopathic Association (AOA), Council of Medical Specialty Societies (CMSS), Federation of Medical Regulatory Authorities of Canada (FMRAC), Federation of State Physician Health Programs (FSPHP), several provincial medical regulatory colleges from Canada, subject matter experts from Justice3D, PBI Education, and additional physician experts, and especially the victim and survivor advocates who were brave enough to share their experiences with Workgroup members. This report has been enriched by these partners’ valuable contributions.

Sexual harassment is common in medicine, and particularly in academic medicine. The National Academies of Sciences reports that organizational culture plays a primary role in enabling harassment and that sexually harassing behaviors are not typically isolated incidents. Medical students and trainees who work within such cultures are often impacted by them; women in medicine who become victims of sexual harassment, beyond suffering from their victimhood, are also undermined in their professional and education attainment, resulting in loss of talent; men educated in these environments, if not the object of sexual harassment themselves, are also impacted; and ultimately patients experience some of the most significant and most dire consequences of such a culture.

Does a culture that is permissive of sexual harassment result in greater permissiveness of physician sexual misconduct with patients? Are bystanders in such a culture more accepting of that culture and less likely to report abuses? These questions emphasize the critical need for promoting a diverse, inclusive, and respectful environment for medical education and care.

The overwhelming majority of physicians carefully observes the boundaries between themselves and their patients and surrogates and, therefore, a small minority of physicians is responsible for the majority of cases of sexual misconduct. However, the Workgroup acknowledged the existence of several highly problematic aspects of sexual misconduct in medical education and practice, many of which permeate the prevailing culture of medicine and self-regulation. These go beyond the many instances, both reported and unreported, of sexual assault and boundary violations to include various aspects of the investigative and adjudicatory processes designed to address them; the professional responsibility of health care practitioners to report suspected instances of sexual misconduct and patient harm; transparency of state medical board processes and actions; a widespread need for education and training among medical regulators, board investigators, attorneys, and law enforcement personnel about trauma and how it might impact complainant accounts and the investigative process; and certain nuances involved in difficult decisions about re-entry to practice and remediation. This report is designed to summarize many of these problematic elements so that they may be more widely appreciated, while offering potential solutions and strategies for state medical boards to consider for their jurisdictions.

The workgroup acknowledges variation in state medical boards policies and processes, as well as in state laws. This report aspires to provide best practice recommendations and highlight existing strategies and available tools that allow boards, including board members, executive directors, staff, and attorneys, to best protect the public while working within their established frameworks and resources.

**Section 2: Principles**

The bulk of the content contained in this report is informed by the following principles:

- **Trust**: The physician-patient relationship is built upon trust, understood as a confident belief on the part of the patient in the moral character and competence of their physician.\(^2\) In order to safeguard this trust, the physician must act and make treatment decisions that are in the best interests of the patient at all times.

- **Professionalism**: The avoidance of sexual relationships with patients has been a principle of professionalism since at least the time of Hippocrates. Professional expectations still dictate today that sexual contact or harassment of any sort between a physician and patient is unacceptable.

- **Fairness**: The principle of fairness applies to victims (also sometimes described as survivors) of sexual misconduct in that they must be granted fair treatment throughout the regulatory process and be afforded opportunities to seek justice for wrongful conduct committed against them. Fairness also applies to physicians who are subjects of complaints in that they must be granted due process in investigative and adjudicatory processes and proportionality must factor into disciplinary actions.

- **Transparency**: The actions and processes of state medical boards are designed in the public interest to regulate the medical profession and protect patients from harm. As such, the public has a right to information about these processes and the bases of regulatory decisions.

**Section 3: Terminology:**

*Sexual Misconduct:*

Physician sexual misconduct is behavior that exploits the physician-patient relationship in a sexual way. Sexual behavior between a physician and a patient is never diagnostic or therapeutic. This behavior may be verbal or physical, can occur in-person or virtually,\(^3\) and may include expressions of thoughts and feelings or gestures that are of a sexual nature or that reasonably may be construed by a patient or patient’s surrogate\(^4\) as sexual. While the focus of this report is on the patient and the patient’s surrogate, physician sexual misconduct can also take place

---


\(^3\) Federation of State Medical Boards, *Social Media and Electronic Communication*, 2019.

\(^4\) Surrogates are those individuals closely involved in patients’ medical decision-making and care and include spouses or partners, parents, guardians, and/or other individuals involved in the care of and/or decision-making for the patient.
between a physician and colleagues, staff, students and trainees. Hereinafter, the term “patient” includes the patient and/or patient surrogate whose sexual boundaries have been violated.

Physician sexual misconduct often takes place along a continuum of escalating severity. This continuum comprises a variety of behaviors and expressions, sometimes beginning with “grooming” behaviors which may not necessarily constitute misconduct on their own, but are precursors to other, more serious violations. These behaviors may include gift-giving, special treatment, sharing of personal information or other acts or expressions that are meant to gain a patient’s trust and acquiescence to subsequent abuse. When the patient is a child, adolescent or teenager, the patient’s parents may also be groomed to gauge whether an opportunity for sexual abuse exists.

More severe forms of misconduct include sexually inappropriate or improper gestures or expressions that are seductive, sexually suggestive, disrespectful of patient privacy, or sexually demeaning to a patient. These may not necessarily involve physical contact, but can have the effect of embarrassing, shaming, humiliating or demeaning the patient. Instances of such sexual impropriety can take place in-person, online, by mail, by phone, and through texting.

Additional examples of sexual misconduct involve physical contact, such as performing an intimate examination on a patient with or without gloves and without clinical justification or explanation of its necessity, and without obtaining informed consent.

The level of severity of sexual misconduct rises in instances where physical sexual contact takes place between a physician and patient, whether or not initiated by the patient, and where any conduct with a patient is indeed sexual or may be reasonably interpreted as sexual. So-called “romantic” behavior between a physician and a patient is never appropriate, regardless of the appearance of consent on the part of the patient. Such behavior would at least constitute grooming, depending on the nature of the behavior, if not actual sexual misconduct, and should be labeled as such.

The term “sexual assault” refers to any type of sexual activity or contact without consent (such as through physical force or threats of force) and may be used in investigations where there is a need to emphasize the severity of the misconduct and any related trauma. Sexual assault is a criminal or civil violation and would typically be initially handled by law enforcement.

While the legal term “sexual boundary violation” is a way of denoting the breach of an imaginary line that exists between the doctor and patient or surrogate, and is commonly used in medical regulatory discussions, the members of the workgroup felt that it was an overly broad term that may encompass everything from isolated instances of inappropriate communication to sexual misconduct and outright sexual assault. As such, the term is avoided in this report in favor of more specific terms.

---

Trauma:

For the purposes of this report, the definition of trauma provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) is used:

“Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.”

According to SAMHSA, “a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.”

Patient:

A patient is understood as an individual with whom a physician is involved in a care and treatment capacity within a legally defined and professional physician-patient relationship.

Sexual misconduct may still occur following the termination of a physician-patient relationship, especially in long-standing relationships or ones involving a high degree of emotional dependence. Time elapsed between termination of the relationship is insufficient in many contexts to determine that sexual contact is permissible. Other factors that should be considered in assessing the possible permissibility of consensual sexual contact between consenting adults following the termination of a physician-patient relationship can include documentation of formal termination; transfer of the patient's care to another health care provider; the length of time of the professional relationship; the extent to which the patient has confided personal or private information to the physician; the nature of the patient's health problem; and the degree of emotional dependence and vulnerability. Termination of a physician-patient relationship for the purposes of allowing sexual contact to legally occur is unacceptable and would still constitute sexual misconduct because of the trust, inherent power imbalance between a physician and patient, and patient vulnerability that exist leading up to, during and following the decision to terminate the relationship. A patient is not capable of providing free, full and informed consent to sexual activity with their physician.

---


7 Id.

Section 4: Patient Rights and Professional Expectations in the Physician-Patient Encounter

Informed Consent and Shared Decision-Making

The informed consent process can be a useful way of helping a patient understand the intimate nature of a proposed examination, as well as its medical necessity. The informed consent process should include, at a minimum, an explanation, discussion, and comparison of treatment options with the patient, including a discussion of any risks involved with proposed procedures; an assessment of the patient’s values and preferences; arrival at a decision in partnership with the patient; and an evaluation of the patient’s decision in partnership with the patient. This process must be documented in the patient’s medical record.

The consent process should take place well in advance of any procedure so that the patient has an opportunity to consider the proposed procedure in the absence of competing considerations about cancellation or rescheduling. Requiring decisions at the point of care puts patients at a disadvantage because they may not have time to consider what is being proposed and what it means for themselves and their values. The consent process should also include information about the effects of anaesthesia, including the possibility of amnesia. Use of understandable (lay, or common) language during the consent process is essential.

Communication and Patient Education

Communication between a physician and patient should occur throughout any examination or procedure, including conveying the medical necessity, what the examination or procedure will involve, the benefits and risks, and any findings. This is especially important during the performance of an intimate examination. In such instances, it may also be helpful for physicians to acknowledge the intimate and invasive nature of the examination while offering as much explanation and justification as possible.

The use of educational resources to educate patients about what is normal and expected during medical examinations and procedures is encouraged and should be provided by both physicians and state medical boards.

Section 5: Complaints and the Duty to Report

In order for state medical boards to effectively address instances of sexual misconduct, they must have access to relevant information about licensees that have harmed or pose a significant risk of harming patients. The complaints process and physicians’ professional duty to report instances of sexual misconduct are therefore central to a regulatory board’s ability to protect patients.9

9 Additional reporting to entities other than state medical boards may also be warranted for purposes of patient protection, including law enforcement, hospital or medical staff administration, and medical school or residency program directors and supervisors.
Complaints and Barriers to Complaints

It is essential for patients or their surrogates to be able to file complaints about their physicians to state medical boards in order that licensees who pose a threat to patients may be investigated and intervention can occur when needed. However, studies have estimated that sexual misconduct by physicians is significantly under reported, and several challenges which may dissuade patients from filing complaints must be overcome. These include institutional distrust in the ability or willingness of state medical boards, hospitals and other health care institutions and sites to take action in instances of sexual misconduct; fear of abandonment or retaliation by the physician; societal or personal factors related to stigma and shame, embarrassment and not wanting to relive a traumatic event; a lack of awareness about the role of state medical boards and how to file complaints; or uncertainty that what has transpired is, indeed, unprofessional and unethical.

State medical boards can play an important role in providing clarity about the complaints process through the provision of information to the public about this process and how, why, and when to file a complaint. State medical boards can also restore public trust and confidence in this process by demonstrating appropriate action on verified complaints. The complaints process should also be accessible to patients with information about filing complaints that is clearly posted on state medical board websites. State medical boards, the FSMB and its partner organizations representing medical specialties whose members perform intimate examinations and procedures may also wish to provide education to patients about the types of behavior that should be expected of physicians, what types of behavior might warrant a complaint, what to do in the event that actions on the part of a physician make a patient uncomfortable, and circumstances that would warrant a report to law enforcement.

The ability to file a complaint anonymously may be especially important in instances of sexual misconduct, given the trauma and fear associated with sexual misconduct. These can serve as barriers to legitimate complaints, especially when anonymity is not granted.

Complaints related to sexual misconduct should be prioritized by state medical boards and addressed as quickly as possible for the benefit and protection of the complainant and other patients.

State medical boards and board investigators of administrative complaints are encouraged to communicate frequently with complainants throughout the complaint and investigative processes and to ask complainants about their preferred mode and frequency of communication, as well as their expectations from the process. Where possible, boards should consider having a patient liaison or advocate on staff who would be specially trained to provide one-on-one support to complainants and their families.

Duty to Report

In a complaint-based medical regulatory system, it is imperative that state medical boards have access to the information they require to effectively protect patients. In addition to a robust complaints process, it is essential that patients, physicians and everyone involved in healthcare adopt a position of speaking up whenever something unusual, unsafe or inappropriate occurs. Institutions, including state medical boards, hospitals and private medical clinics also have a duty to report instances of sexual misconduct and other serious patient safety issues and events.

Early reporting of instances of sexual misconduct is critical, including reporting of those forms of misconduct at the less egregious end of the spectrum falling under potential grooming behaviors. Evidence exists which demonstrates that less egregious violations that go unreported frequently lead to more egregious ones. These egregious acts are almost always committed in private or after hours where they cannot be witnessed by parties external to the physician-patient encounter and therefore go unreported. Early reporting is therefore one of the only ways in which sexual abuse of patients can be prevented from impacting more patients.

The moral imperative to report has proven insufficient in recent years, however, to equip state medical boards with adequate information to stop or prevent licensees from engaging in sexual misconduct. There are likely several factors that prevent reporting from occurring, including the corporatization of medical practice, which has led many institutions to deal with instances of misconduct internally. While corporatization increases accountability for many physicians and internal processes may be effective in addressing some types of sexual misconduct, it can also cause some institutions to neglect required reporting and the need for transparency. Physicians may also avoid reporting because of the moral distress and profound discomfort many physicians feel when asked to report their colleagues, and the impracticality of reporting where power dynamics exist and where stakes are high for reporters.

Alternative strategies and approaches should be considered, rather than relying on professional or moral duties alone. State medical boards should have the ability to levy fines against institutions for failing to report instances of egregious conduct. While many states already have statutory ability to do so, they are reluctant to engage in legal proceedings with hospitals or other institutions with far greater resources at their disposal.

Results of hospital and health system peer review processes should also be shared with state medical boards when sexual misconduct is involved. This type of conduct is fundamentally different from other types of peer review data related to performance and aimed at quality improvement and, while still relevant to medical practice, should be subject to different rules regarding reporting. Hospitals should also be required to report to state medical boards instances where employed physicians have been dismissed or are forced to resign due to concerns related to sexual misconduct.

In situations where professional hierarchies exist and there are concerns about retaliation related to medical school matriculation, training positions, careers or promotions, reporting parties should be empowered to uphold professional standards in the interests of patients and the

profession. Cultivation of positive behavior through role modelling and clear guidance based on
the values of the profession should be set by multiple parties, not the state medical board alone.
A broader notion of professionalism should be adopted that goes beyond expectations for
acceptable conduct to include a duty to identify instances of risk or harm to patients, thereby
making non-reporting professionally unacceptable. Physicians who fail to report known
instances of sexual misconduct should be liable for sanction by their state medical board for the
breach of their professional duty to report.

Unscrupulous, frivolous or vexatious reporting motivated by competition is counterproductive to
fulfilling this notion of professionalism and protecting the public, so it should be met with
disciplinary action. Processes for reporting and complaints should be normalized by making
them a collective, rather than individual, responsibility to help physicians feel less like
investigators and more like responsible stewards of professional values. Those physicians and
other individuals who do report in good faith should be protected from retaliation and given the
option to remain anonymous.

State medical boards also have a duty to report egregious violations or instances of criminal
behavior to law enforcement. When reporting requirements are unclear, consultation with a
board attorney is recommended.

Section 6: Investigations

State Medical Board Authority

It is imperative that state medical boards have sufficient statutory authority to investigate
complaints and any reported allegations of sexual misconduct. State medical boards should place
a high priority on the investigation of complaints of sexual misconduct due to patient
vulnerability unique to such cases. The purpose of the investigation is to determine whether the
report can be substantiated in order to collect sufficient facts and information for the board to
make an informed decision as to how to proceed. If the state medical board’s investigation
indicates a reasonable probability that the physician has engaged in sexual misconduct, the state
medical board should exercise its authority to intervene and take appropriate action to ensure the
protection of the patient and the public at large.

Each complaint should be investigated and judged on its own merits. Where permitted by state
law, the investigation should include a review of previous complaints to identify any such
patterns of behavior, including malpractice claims and settlements. In the event that such patterns
are identified early in the investigation, or the physician has been the subject of sufficient
previous complaints to suggest a high likelihood that the physician presents a risk to future
patients, or in the event of evidence supporting a single egregious misconduct event, the state
medical board should have the authority to impose terms or limitations, including suspension, on
the physician’s license prior to the completion of the investigation.

The investigation of all complaints involving sexual misconduct should include interviews with
the physician, complainant(s) and/or patient and/or patient surrogate. The investigation may
include an interview with a current or subsequent treating practitioner of the patient and/or
patient surrogate; colleagues, staff and other persons at the physician’s office or worksite; and
persons that the patient may have told of the misconduct. Physical evidence and police reports
can also be valuable in providing a more complete understanding of events.

In many states, a complaint may not be filed against a physician for an activity that occurred
beyond a certain time threshold in the past. There is a growing trend among state legislatures in
recent years to extend or remove the statute of limitations in cases of rape and other forms of
sexual misconduct. Given the impact that trauma can have on a victim of sexual misconduct, the
length of time that it may take to understand that a violation has occurred, to come to terms with
it, or be willing to relive the circumstances as part of the complaints process, the members of the
workgroup feel that no limit should be placed on the amount of time that can elapse between
when an act of misconduct occurred and when a complaint can be filed.

Complainant Sensitivity to Investigation

Because of the delicate nature of complaints of sexual misconduct and the potential trauma
associated with it, state medical boards should have special procedures in place for interviewing
and interacting with such complainants and adjudicating their cases. In cases involving trauma,
emotions may not appear to match the circumstances of the complaint, seemingly salient details
may be unreported or unknown to the complainant, and the description of events may not be
recounted in linear fashion. Symptoms of trauma may therefore be falsely interpreted as signs of
deception by board investigators or those adjudicating cases.

Professionals who are appropriately trained and certified in the area of sexual misconduct and
victim trauma should conduct the state medical board’s investigation and subsequent
intervention whenever possible. Best practices in this area suggest that board members should
also undergo specialized training in victim trauma. It is further recommended that all board staff
who work with complainants in cases involving sexual misconduct undergo this training to
develop an understanding of how complainants’ accounts in cases involving trauma can differ
from other types of cases. This can inform reasonable expectations on behalf of those
investigating and adjudicating these cases and help eliminate biases. The FSMB and state
medical boards should work to ensure the availability of high-quality training in trauma and a
trauma-informed approach to investigations.

Where state medical boards have access to investigators of different genders, boards should seek
the complainant’s preference regarding the gender of investigators and assign them accordingly.
State medical boards should also allow inclusion of patient advocates in the interview process
and treat potential victims (survivors) with empathy, humanity, and in a manner that encourages
healing. Questioning of both complainants and physicians should take the form of an
information-gathering activity, not an aggressive cross-examination.
Section 7: Comprehensive Evaluation

State medical boards regularly use diagnostic evaluations for health professionals who may have a physical or mental impairment. Similarly, the use of diagnostic evaluations when handling a complaint regarding sexual misconduct provides significant information that may not otherwise be revealed during the initial phase of the investigation. A comprehensive evaluation may be valuable to the board’s ability to assess future risk to patient safety.

A comprehensive evaluation is not meant to determine findings of fact. Rather, its purpose is to:

- assess and define the nature and scope of the physician’s behavior,
- identify any contributing illness, impairment, or underlying conditions that may have predisposed the physician to engage in sexual misconduct or that might put future patients at risk,
- assist in determining whether a longstanding maladaptive pattern of inappropriate behavior exists, and
- make treatment recommendations if rehabilitative potential is established.

If its investigation reveals a high probability that sexual misconduct has occurred, the state medical board should have the authority to order an evaluation of the physician and the physician must be required to consent to the release to the board all information gathered as a result of the evaluation. The evaluation of the physician follows the investigation/intervention process but precedes a formal hearing.

The evaluation of a physician for sexual misconduct is complex and may require a multidisciplinary approach. Where appropriate, it should also include conclusions about fitness to practice.

Section 8: Hearings

Following investigation and evaluation (if appropriate), the state medical board should determine whether sufficient evidence exists to proceed with formal charges against the physician. In most jurisdictions, initiation of formal charges is public and will result in an administrative hearing unless the matter is settled.

Initiation of Charges

In assessing whether sufficient evidence exists to support a finding that sexual misconduct has occurred, corroboration of a patient’s testimony should not be required. Although establishing a pattern of sexual misconduct may be significant, a single case is sufficient to proceed with a formal hearing. State medical boards should have the authority to amend formal charges to include additional complainants identified prior to the conclusion of the hearing process.
Open vs Closed Hearings

If state medical boards are required, by statute, to conduct all hearings in public, including cases of sexual misconduct, many patients may be hesitant to come forward in a public forum and relate the factual details of what occurred. State medical boards should have the statutory authority to close the hearing during testimony which may reveal the identity of the patient. The decision to close the hearing, in part or in full, should be at the discretion of the board. Neither the physician nor the witness should control this decision. Boards should allow the patient the option of having support persons available during both open and closed hearings.

Patient Confidentiality

Complaints regarding sexual misconduct are highly sensitive. Therefore, enhanced attention must be given to protecting a patient’s identity, including during board discussion, so that patients are not discouraged from coming forward with legitimate complaints against physicians. State medical boards should have statutory authority to ensure nondisclosure of the patient’s identity to the public. This authority should include the ability to delete from final public orders any patient identifiable information.

Testimony

Sexual misconduct cases involve complex issues; therefore, state medical boards may consider the use of one or more expert witnesses to fully develop the issues in question and to define professional standards of care for the record. Additionally, the evaluating/treating physician or mental health care practitioners providing assessment and/or treatment to the respondent physician may be called as witnesses. The evaluating clinician may provide details of treatment, diagnosis and prognosis, especially the level of insight and change by the practitioner. Also, a current or subsequent treating practitioner of the patient, especially a mental health provider, may be called as a witness. All these witnesses may provide insight into factors that led to the alleged sexual misconduct, an opinion regarding the level of harm incurred by the patient, and describe the physician’s rehabilitative potential and risk for recidivism.

Implicit Bias

In any case that comes before a state medical board, it is important for those responsible for adjudicating the case to be mindful of any personal bias that may impact their review and adjudication. Bias can be particularly strong where board members themselves have been victims of sexual assault or have been subject to previous accusations regarding sexual misconduct. Training about implicit bias is recommended for board members and staff in order to help identify implicit bias and mitigate the impact it may have on their work.12

12 Project Implicit, accessed November 13, 2019 at https://implicit.harvard.edu/implicit/
Section 9: Discipline

State medical boards have a broad range of disciplinary responses available to them that are designed to protect the public. Upon a finding of sexual misconduct, the board should take appropriate action and impose one or more sanctions reflecting the severity of the conduct and potential risk to patients. Essential elements of any board action include a list of mitigating and aggravating factors, an explanation of the violation in plain language, clear and understandable terms of the sanction, and an explanation of the consequences associated with non-compliance.

Findings of even a single case of sexual misconduct are often sufficiently egregious as to warrant revocation of a physician’s medical license. A physician’s license should be automatically revoked if they are judged to have committed sexual assault, illegal activity, egregious acts of a sexual nature, or knowingly caused significant patient harm or the threat of harm. State medical boards should also consider revocation in instances where a physician has repeatedly committed lesser acts, especially following remedial efforts.

It is likely that any instance of sexual misconduct would provide sufficient grounds for revocation of licensure. However, in a limited set of instances, state medical boards may find that mitigating circumstances do exist and, therefore, stay the revocation and institute terms and conditions of probation or other practice limitations. In the event that the board makes a finding of sexual impropriety, the board may consider a less severe sanction than for a finding of sexual violation.

In determining an appropriate disciplinary response, the board should consider the factors listed in Table 1.
Table 1: Considerations in determining appropriate disciplinary response

<table>
<thead>
<tr>
<th>Patient Harm</th>
<th>Age and competence of patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity of impropriety or inappropriate behavior</td>
<td>Vulnerability of patient</td>
</tr>
<tr>
<td>Context within which impropriety occurred</td>
<td>Number of times behavior occurred</td>
</tr>
<tr>
<td>Culpability of licensee</td>
<td>Number of patients involved</td>
</tr>
<tr>
<td>Psychotherapeutic relationship</td>
<td>Period of time relationship existed</td>
</tr>
<tr>
<td>Existence of a physician-patient relationship</td>
<td>Evaluation/assessment results</td>
</tr>
<tr>
<td>Scope and depth of the physician-patient relationship</td>
<td>Prior professional misconduct/disciplinary history/malpractice</td>
</tr>
<tr>
<td>Inappropriate termination of physician-patient relationship</td>
<td>Recommendations of assessing/treating professional(s) and/or state physician health program</td>
</tr>
<tr>
<td>Age and competence of patient</td>
<td>Risk of reoffending</td>
</tr>
</tbody>
</table>

Boards should not routinely consider romantic involvement, patient initiation or patient consent a legal defense. A patient shall be presumed to be incapable of giving free, full, and informed consent to sexual activity with his or her physician.

Society's values and beliefs evolve, and some individuals may be slower to abandon long-held beliefs, even where these may be sexist or prejudiced in other ways. However, adherence to an outdated set of generational values that has since been found to be unacceptable is not a reason to overlook or excuse sexual misconduct.

The potential existence of a physician workforce shortage or maldistribution, or arguments related to particular restrictions being tantamount to taking a physician “out of work” should also not be used as reasons for leniency or for allowing patients to remain in harm’s way. In cases involving sexual misconduct, it is simply not true that unsafe or high-risk care is better than no care at all. A single instance, let alone many instances, can cause an extremely high degree of damage to individuals and the communities in which they reside. However, staying true to the principle of proportionality also means considering the fact that some forms of discipline,

---

13 Broadly understood as inclusive of physical and emotional harm, resulting distrust in the medical system and avoidance of future medical treatment, and other related effects of trauma.
including public notifications, generate significant shame upon the disciplined physician. This can compound the degree of severity of a disciplinary action and may be taken into consideration by state medical boards.

Temporary or Interim Measures:

In the event that a state medical board decides to remove a licensee from practice or limit the practice of a licensee as a temporary measure in order to reduce the risk of patient harm while an investigation takes place, there are several different interim measures that can be used. Common measures include an interim or summary suspension/cessation of practice, restrictions from seeing patients of a certain age or gender, restrictions from seeing patients altogether, or the mandatory use of a practice monitor (sometimes referred to as a chaperone) for all patient encounters.\textsuperscript{14} The appropriateness of age and gender-based restrictions should be considered carefully before being imposed by state medical boards. Sexual misconduct often occurs for reasons related to power, rather than because of a sexual attraction to a particular gender or age group, thereby making these restrictions ineffective to protect patients in many cases. Boards should also consider whether a physician who is willing to commit acts of sexual misconduct involving a patient of any gender or age should be permitted to continue to treat patients, or whether their actions were sufficiently egregious and contrary to the principles of the profession to justify a restriction from seeing patients altogether. If gender-based restrictions are used by state medical boards, consideration may also be given to coupling these restrictions with additional regulatory interventions such as education, monitoring or other forms of probation.

Remediation

As discussed above, many forms of sexual misconduct and harmful actions that run against the core values of medicine should appropriately result in automatic revocation of licensure. However, there may be some less egregious forms of sexual misconduct with mitigating circumstances for which a physician may be provided the option of participating in a program of remediation to be able to re-enter practice or have license limitations lifted following a review and elapse of an appropriate period of time.

The members of the workgroup acknowledge that shortcomings exist in the current evidence base regarding the effectiveness of remediation in instances of sexual misconduct. The model for remediation proposed in this report is, therefore, extrapolated from the generally accepted model for addressing gaps in knowledge and performance\textsuperscript{15} and applied to the context of sexual misconduct, which may not be the ideal model. The workgroup feels that further research is needed in this area.

In determining whether remediation is feasible for a particular physician, state medical boards may wish to make use of a risk stratification methodology that considers the severity of actions committed, the mitigating and aggravating factors listed in section 9 above (Discipline), the character of the physician, including insight and remorse demonstrated, as well as an

\textsuperscript{14} Please refer to the discussion about practice monitors and chaperones below.

\textsuperscript{15} Hauer, et al. Remediation of the Deficiencies of Physicians Across the Continuum from Medical School to Practice: A Thematic Review of the Literature, \textit{Acad Med}, Vol. 84, No. 12 / December 2009
understanding of why their actions were morally wrong, and the perceived likelihood that they may reoffend. The consequences to patients and the general public of allowing a physician to engage in remediation and re-enter practice after a finding of sexual misconduct should be considered, including any erosion of the public trust in the medical profession and the role of state medical boards.

The goals of the remediation process should be clearly outlined, including expectations for acceptable performance on the part of the physician. The process of remediation should relate to the physician’s offense and be targeted to identified gaps in understanding of their particular vulnerabilities and other risks for committing sexual misconduct. Assessment and remediation partners should therefore be provided access to investigative information in order to properly tailor remedial education to the particular context in which the misconduct occurred. Finally, state medical boards should be mindful that remediation cannot typically be said to have “occurred” following successful completion of an educational course. Rather, a longitudinal mechanism should be established for maintaining the physician’s engagement in a process of coming to terms with their misconduct and avoiding the circumstances that led to it.

State medical boards should be mindful that not all physicians who have committed sexual misconduct are capable of remediation. Reinstatement and monitoring in such a context would therefore be inappropriate. For those who are considered for remediation, if at any point it becomes clear that a physician presents a risk of reoffending or otherwise harming patients, the remediation process should be abandoned, and reinstatement should not occur.

License Reinstatement/Removal of LicenseRestriction(s)

In the event of license revocation, suspension, or license restriction, any petition for reinstatement or removal of restriction should include the stipulation that a current assessment, and if recommended, successful completion of treatment, be required prior to the medical board’s consideration to assure the physician is competent to practice safely. Such assessment may be obtained from the physician’s treating professionals, state physician health program (PHP),16 or from an approved evaluation team as necessary to provide the board with adequate information upon which to make a sound decision.

Transparency of board actions:

As state medical boards regulate the profession in the interest of the public, it is essential that evolving public values and needs are factored into decisions about what information is made publicly available. It has been made clear in academic publications and popular media, as well as through the #MeToo and TimesUp movements that the public increasingly values transparency regarding disciplinary actions imposed on physicians. It is likely that any action short of a complete revocation of licensure will draw scrutiny from the public and popular media. Such scrutiny can also be expected regarding decisions to reinstate a license or remove restrictions.

16“A Physician Health Program (PHP) is a confidential resource for physicians, other licensed healthcare professionals, or those in training suffering from addictive, psychiatric, medical, behavioral or other potentially impairing conditions. PHPs coordinate effective detection, evaluation, treatment, and continuing care monitoring of physicians with these conditions.” Source: Federation of State Physician Health Programs.
The public availability of sufficient facts to justify a regulatory decision and link it to a licensee’s behavior and the context in which it occurred can help state medical boards to explain and justify their decision.

The ability to disclose particular details of investigative findings and disciplinary actions is limited by state statute in many jurisdictions. State medical boards are encouraged to convey this fact to the public in order to protect the trust that patients have in boards, but also make efforts to achieve legislative change, allowing them to publicize information that is in the public interest. Where disclosure is possible, boards should select means for conveying information that will optimally reach patients. This should include making information available on state medical board websites and reporting to the FSMB Physician Data Center, thereby also making information about disciplinary actions publicly available through FSMB’s docinfo.org website, and the National Practitioner Data Bank. Boards should also consider additional means of communicating, such as through mobile phone applications, notices in newspapers and other publications. California and Washington both require that patients be notified of sexual misconduct license stipulations/restrictions at the time of making an appointment and that the patient verify this notification.

State medical boards are also encouraged to implement clear coding processes for board actions that provide accurate descriptions of cases, and clearly link licensee behaviors to disciplinary actions. Where sexual misconduct has occurred, the case should be labeled as such. A label of “disruptive physician behavior” or even “boundary violation” is less helpful than the more specific label of “sexual misconduct.” State medical boards and the FSMB should work together to develop consistent terminology that allows greater understanding for the public and the state medical boards, while also enabling the tracking of trends, frequencies, recidivism and the impact of remedial measures.

Where particular actions on the part of the physician may not meet a threshold for disciplinary action, but might nonetheless constitute grooming behaviors, state medical boards should consider ways in which to allow previously dismissed cases to be revisited during subsequent cases, such as through non-disciplinary letters of education or concern which remain on a licensee’s record. The ability to revisit previous cases involving seemingly minor events can help identify patterns of behavior in a licensee and provide additional insight into whether a licensee poses a risk to future patients.

Section 10: Monitoring

Following a finding of sexual misconduct, if a license is not revoked or suspended, it is essential that a state medical board establish appropriate monitoring of the physician and their continued practice. Monitoring in the context of sexual misconduct occurs differently from monitoring substance use disorders and the resources available to boards differ from state to state. Many PHPs do not offer monitoring services for physicians who have faced disciplinary action because

17 The Medical Board of California has launched a new mobile application allowing patients to receive updates about their physician, including licensure status and practice location.
of sexual misconduct and even where such monitoring by a PHP is possible, it is typically only part of a way forward, rather than a solution on its own.

For the purposes of this report, the members of the workgroup understand the use of a chaperone as an informal arrangement of impartial observation, typically initiated by physicians themselves. A chaperone in this context is meant to protect the doctor in the event of a complaint, although their presence may also offer comfort to the patient. The patient may request that the chaperone not be present for any portion of the clinical encounter. The workgroup acknowledges that the use of chaperones has been discontinued in some international jurisdictions and by particular state medical boards, because of a belief that they merely provide the illusion of safety and may therefore allow harmful behaviors to go unnoticed. There is risk of this occurring in instances where a chaperone is untrained or uninformed about their role, is an employee or colleague of the physician being monitored or does not adequately attend to their responsibilities.

A practice monitor differs from a chaperone. We define a practice monitor as part of a formal monitoring arrangement mandated by a state medical board, required at all patient encounters, or all encounters with patients of a particular gender or age. The practice monitor’s primary responsibility is to the state medical board and their presence in the clinical encounter is meant to provide protection to the patient through observation and reporting. Costs associated with employing a practice monitor are typically borne by the monitored physician, but practices may vary across states. The patient must be informed that the practice monitor’s presence is required as part of a practice restriction. As the practice monitor is mandated for all clinical encounters, the patient may not request that the practice monitor not be present for any portion of the encounter. If a patient is uncomfortable with the presence of a practice monitor, they will need to seek care from a different physician. Patient supports (parents, family members, friends) may be present during examinations but do not replace, nor can they be used in lieu of a board mandated practice monitor.

While even this formal arrangement with a clearly defined role, training and direct reporting may have limitations, the practice monitor may be a useful option for boards in certain specific circumstances. In particular, in instances where there is insufficient evidence to remove a physician from practice altogether, but significant risk is believed to be present, the opportunity to mandate practice monitoring provides boards with an additional option, short of allowing a potentially risky physician to return to independent practice. As such, when practice monitors are implemented judiciously, the Workgroup believes that their use can enhance patient safety and should therefore be considered by state medical boards.

Practice monitors should only be used if the following conditions have been met:

- The practice monitor has undergone formal training about their role, including their primary responsibility and direct reporting relationship to the state medical board (as opposed to the physician being monitored).

---

18 Paterson, R. Independent review of the use of chaperones to protect patients in Australia, Commissioned by the Medical Board of Australia and the Australian Health Practitioner Regulation Agency, February 2017.
It is highly recommended that all practice monitors have clinical backgrounds. If they do not, their training must include sufficient content about clinical encounters so they can be knowledgeable about what is and is not appropriate as part of the monitored physician’s clinical encounters with patients.

The practice monitor should be approved by the state medical board and cannot be an employee or colleague of the monitored physician that may introduce bias or otherwise influence their abilities to serve as a practice monitor and report to the board or intervene when necessary. Pre-existing contacts of any sort are discouraged, but where a previously unknown contact is not available, the existing relationship should be disclosed. In some states, practice monitors are required to be active licensees of another health profession as it is felt that this reinforces their professional duty to report. When health professionals serve as practice monitors, they should not have any past disciplinary history.

The practice monitor has been trained in safe and appropriate ways of intervening during a clinical encounter at any point where there is confidence of inappropriate behavior on the part of the physician, the terms of the monitoring agreement are not being followed, or a patient has been put at risk of harm.

The practice monitor submits regular reports to the state medical board regarding the monitored physician’s compliance with monitoring requirements and any additional stipulations made in a board order.

Where possible, state medical boards should consider establishing a panel of different practice monitors that will rotate periodically among monitored physicians to ensure monitor availability and that a collegial relationship does not develop between a practice monitor and a monitored physician, unduly influencing the nature of the monitoring relationship.

Monitoring should be individualized and based on the findings of the multidisciplinary evaluation, and, as appropriate, subsequent treatment recommendations. If a diagnosis of contributory mental/emotional illness, addiction, or sexual disorder has been established, the monitoring of that physician should be the same as for any other mental impairment and state medical boards are encouraged to work closely with their state physician health program as a resource and support in monitoring. Conditions, which may also be used for other violations of the medical practice act, may be imposed upon the physician. Examples are listed in Table 2.
### Table 2: Possible Conditions of Practice Following a Finding of Sexual Misconduct

- Supervision of the physician in the workplace by a supervisory physician
- Requirement that practice monitors are always in attendance and sign the medical record attesting to their attendance during examination or other patient interactions as appropriate.
- Periodic on-site review by board investigator or physician health program staff if indicated.
- Practice limitations as may be recommended by evaluator(s) and/or the state physicians health program.
- Regular interviews with the board and/or state physician health program as required to assess status of probation.
- Regular reports from a qualified and approved licensed practitioner, approved in advance by the board, conducting any recommended counseling or treatment.
- Completion of a course in maintaining appropriate professional boundaries, which shall be approved in advance of registration by the board.

---

### Section 11: Education

Education and training about professional boundaries in general and physician sexual misconduct in particular should be provided during medical school and residency, as well as throughout practice as part of a physician’s efforts to remain current in their knowledge of professional expectations. This should include education about the prevalence of victimization and abuse in the general population and the fact that more than half of patients who are exploited sexually by physicians have been exploited before. State medical boards and the FSMB should take a proactive stance to educate physicians, board members and board staff about sexual misconduct and the effects of trauma. Members of state medical boards and those responsible for adjudicating cases involving sexual misconduct can also experience trauma. Education for dealing appropriately with traumatic elements of cases and finding appropriate help and resources would also be valuable for board members.

Education and training should include information about professionalism and the core values of medicine; the nature of the physician-patient relationship, including the inherent power imbalance and the foundational role of trust; acceptable behavior in clinical encounters; and methods of reporting instances of sexual misconduct. For both medical schools and residency
programs, this education and training should also include tracking assessment across the curriculum, identification of deficiencies in groups and individuals, remediation, and reassessment for correction, appropriate self-care, and the potential for developing psychiatric illness or addictive behaviors. Early identification of risk for sexual misconduct and unprofessionalism is central to public protection and maintaining public trust.

For practicing physicians, because of lack of education or awareness, physicians may encounter situations in which they have unknowingly violated the medical practice act through boundary transgressions and violations. A reduction in the frequency of physician sexual misconduct may be achieved through education of physicians and the health care team.

Resources should also be made available to physicians to help them develop better insight into their own behavior and its impact on others. These could include multi-source feedback and 360-degree assessments, and self-inventories with follow-up education based on the results. As with apology legislation, the use of these resources and the results from self-assessment or other forms of assistance should not be used against physicians. Such resources would likely be used more broadly if they came from specialty and professional societies, rather than from state medical boards alone.

State medical boards should develop cooperative relationships with state physician health programs, state medical associations, hospital medical staffs, other organized physician groups, and medical schools and training programs to provide physicians and medical students with educational information that promotes awareness of physician sexual misconduct. This information should include a definition of physician sexual misconduct, what constitutes appropriate physician-patient boundaries, how to identify and avoid common “grooming” behaviors, and the potential consequences to both the patient and the physician when professional boundaries are not maintained. Physicians should be educated regarding the degree of harm patients experience as a result of sexual misconduct.

Education for patients is also essential so that they may be better informed about what to expect during a clinical encounter, what would constitute inappropriate behavior, and how to file a complaint with their state medical board. Information about boundary issues, including physician sexual misconduct, should be published in medical board newsletters and pamphlets. Media contacts should be developed to provide information to the public.

Section 12: Summary of Recommendations

The goal of this report is to provide state medical boards with best practice recommendations for effectively addressing and preventing sexual misconduct with patients, surrogates and others by physicians, while highlighting key issues and existing approaches.

The recommendations in this section include specific requests of individual entities, as well as general ones that apply to multiple parties, including state medical boards, the FSMB and other relevant stakeholders. The Workgroup felt strongly that effectively addressing physician sexual
misconduct requires widespread cultural and systemic changes that can only be accomplished through shared efforts across the medical education and practice continuum.

**Culture:**

1. Across the continuum from medical education to practice, continue to eliminate harassment and build culture that is supportive of professional behavior and does not tolerate harassment of any type.

**Transparency:**

2. State medical boards should ensure that sufficient information is publicly available (without breaching the privacy of complaints) to justify regulatory decisions and provide sufficient rationale to support them.

3. State medical boards should implement clear coding processes for board actions that provide accurate descriptions of cases and clearly link licensee behaviors to disciplinary actions.

4. State medical boards and the FSMB should work together to develop consistent terminology for use in board actions that allows greater understanding for the public and the state medical boards, while also enabling the tracking of trends, frequencies, recidivism and the impact of remedial measures. These should support research and the early identification of risk to patients.

5. The means of conveying information to the public about medical regulatory processes, including professional expectations, reporting and complaints processes, and available resources should be carefully examined to ensure maximal reach and impact. New means of communicating should be considered, including through medical board and physician practice websites; as part of the scheduling and registration process for appointments; via mobile apps and other media. These should be considered in addition to traditional media such as print and online.

**Complaints:**

6. State medical boards are encouraged to provide easily accessible information, education and clear guidance about how to file a complaint to the state medical board, and why complaints are necessary for supporting effective regulation and safe patient care. The FSMB and its partner organizations representing medical specialties whose members perform intimate examinations and procedures should provide education to patients about the types of behavior that can be expected of physicians, what types of behavior might warrant a complaint, what to do in the event that actions on the part of a physician make a
patient uncomfortable, and circumstances that would warrant a report to law enforcement.

7. State medical boards and board investigators of administrative complaints are encouraged to communicate frequently with complainants throughout the complaint and investigative process, according to the preferred mode and frequency of communication of the complainant.

8. Complaints related to sexual misconduct should be prioritized by state medical boards and addressed as quickly as possible given their traumatic nature and to protect potential future victims.

9. State medical boards should have a specially trained patient liaison or advocate on staff who is capable of providing one-on-one support to complainants and their families.

**Reporting:**

10. State medical boards should have the ability to levy fines against institutions for failing to report instances of egregious conduct.

11. Results of hospital and health system peer review processes should be shared with state medical boards when sexual misconduct is involved.

12. Hospitals should be required to report to state medical boards instances where employed physicians have been dismissed or are forced to resign due to concerns related to sexual misconduct.

13. Physicians who fail to report known instances of sexual misconduct should be liable for sanction by their state medical board for the breach of their professional duty to report.

14. Unscrupulous, frivolous or vexatious reporting motivated by competition should be met with disciplinary action.

15. Physicians and other individuals who report in good faith should be protected from retaliation and given the option to remain anonymous.

**Investigations:**

16. If the state medical board’s investigation indicates a reasonable probability that the physician has engaged in sexual misconduct, the state medical board should exercise its authority to intervene and take appropriate action to ensure the protection of the patient and the public at large.
17. Where permitted by state law, investigations should include a review of previous complaints to identify any patterns of behavior, including malpractice claims and settlements.

18. State medical boards should have the authority to impose interim terms or limitations, including suspension, on a physician’s license prior to the completion of an investigation.

19. Limits should not be placed on the amount of time that can elapse between when an act of misconduct occurred and when a complaint can be filed.

20. State medical boards should use trauma-informed procedures when interviewing and interacting with complainants alleging instances of sexual misconduct and adjudicating these cases.

21. State medical board members involved in sexual misconduct cases (either in investigation or adjudication) and all board staff who work with complainants in cases involving sexual misconduct should undergo training in the area of sexual misconduct, victim trauma, and implicit bias.

22. Where possible, boards should seek the complainant’s preference regarding the gender of investigators and assign them accordingly.

23. State medical boards should also allow inclusion of patient advocates in the interview process.

24. The FSMB and state medical boards should work to ensure the availability of high-quality training in trauma and a trauma-informed approach to investigations.

**Comprehensive Evaluation:**

25. State medical boards should have the authority to order a comprehensive evaluation of physicians where investigation reveals a high probability that sexual misconduct has occurred.

**Hearings:**

26. State medical boards should have statutory authority to ensure nondisclosure of the patient’s identity to the public, including by closing hearings in part or in full, and deleting any identifiable patient information from final public orders. Patient identity must also be protected during board discussion.
Discipline:

27. A physician’s license should be automatically revoked if they are found to have committed sexual assault, illegal activity, egregious acts of a sexual nature, or knowingly caused significant patient harm or the threat of harm. State medical boards should also consider revocation in instances where a physician has repeatedly committed lesser acts, especially following remedial efforts.

28. Gender and age-based restrictions should only be used by boards where there is a high degree of confidence that the physician is not at risk of reoffending.

29. Practice monitors should only be used as a means of protecting patients if the conditions outlined in this report have been met, including appropriate training, reporting relationship to the state medical board and lack of pre-existing relationship with the monitored physician.

30. When considering remedial action after sexual misconduct, state medical boards should employ a risk stratification model that also factors in risk of erosion of public trust in the medical profession and medical regulation.

31. As part of remedial efforts, any partners in the assessment and remediation of physicians should be provided access to investigative information in order to properly tailor remedial education to the context in which the sexual misconduct occurred.

32. Following remedial activities, state medical boards should monitor physicians to ensure that they are actively avoiding circumstances that led to their sexual misconduct.

33. State medical boards should consider ways in which to allow previously dismissed cases to be revisited during subsequent cases, such as through non-disciplinary letters of concern or education which remain on a licensee’s record.

Education:

34. Education and training about professional boundaries and physician sexual misconduct should be provided during medical school and residency, as well as throughout practice as part of a physician’s efforts to remain current in their knowledge of professional expectations. This should include education about how to proceed with basic as well as sensitive/intimate exams and the communication with the patients that is required as a component of these exams. This education should be informed by members of the public, as best possible.

35. State medical boards and the FSMB should provide education to physicians, board members and board staff about sexual misconduct and the effects of trauma. This should include resources to help physicians develop better insight into their own behavior and its impacts on others. Resources and materials should be developed in collaboration with
state physician health programs, state medical associations, hospital medical staffs, other
organized physician groups, and medical schools and training programs.

36. As stated in Recommendation #6 regarding complaints, state medical boards are
commented to provide easily accessible information, education and clear guidance about
how to file a complaint to the state medical board, and why complaints are necessary for
supporting effective regulation and safe patient care. The FSMB and its partner
organizations representing medical specialties whose members perform intimate
examinations and procedures should provide education to patients about the types of
behavior that can be expected of physicians, what types of behavior might warrant a
complaint, what to do in the event that actions on the part of a physician make a patient
uncomfortable, and circumstances that would warrant a report to law enforcement.

37. The FSMB, state medical boards, medical schools, residency programs, and medical
specialty and professional societies should provide renewed education on professionalism
and the promotion of professional culture.
Appendix A: Sample Resources

The following is a sample list of resources available to support greater understanding of sexual misconduct, sexual boundaries, the impacts of trauma, and implicit bias. 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.

1. Sexual misconduct, sexual/personal/professional boundaries:
   - AMA: Code of Medical Ethics: Sexual Boundaries
     - Romantic or Sexual Relationships with Patients
     - Romantic or Sexual Relationships with Key Third Parties
     - Sexual Harassment in the Practice of Medicine
   - AMA: CME course: Boundaries for physicians
   - AAOS: Sexual Misconduct in the Physician-Patient Relationship
   - North Carolina Medical Board: Guidelines for Avoiding Misunderstandings During Patient Encounters and Physical Examinations
   - Vanderbilt University Medical Center: Online CME Course: Hazardous Affairs – Maintaining Professional Boundaries
   - Vanderbilt University Medical Center: Boundary Violations Index
   - PBI Education: Professional Boundaries CME

2. Trauma-related resources:
   - SAMHSA: Concept of Trauma and Guidance for a Trauma-Informed Approach
   - National Institute for the Clinical Application of Behavioral Medicine: How Trauma Impacts Four Different Types of Memory
   - Frontiers in Psychiatry: Memory distortion for traumatic events: the role of mental imagery
   - Canadian Department of Justice: The Impact of Trauma on Adult Sexual Assault Victims
   - NIH: Trauma-Informed Medical Care: A CME Communication Training for Primary Care Providers
   - Western Massachusetts Training Consortium: Trauma Survivors in Medical and Dental Settings
   - American Academy of Pediatrics: Adverse Childhood Experiences and the Lifelong Consequences of Trauma
   - Public Health Agency of Canada: Handbook on Sensitive Practice for Health Care Practitioners
   - Psychiatric Times: CME: Treating Complex Trauma Survivors
   - NHS Lanarkshire (Scotland): Trauma and the Brain (Video)
   - London Trauma Specialists: Brain Model of PTSD - Psychoeducation Video
3. **Implicit bias:**

- AAMC: [Online Seminar: The Science of Unconscious Bias and What To Do About it in the Search and Recruitment Process](#)
- AAMC: [Exploring Unconscious Bias in Academic Medicine (Video)](#)
- ASME Medical Education: Non-conscious bias in medical decision making: what can be done to reduce it?
- APHA: [Patient Race/Ethnicity and Quality of Patient–Physician Communication During Medical Visits](#)
- Institute for Healthcare Improvement: [Achieving Health Equity: A Guide for Health Care Organizations](#)
- BMC Medical Education: [Training to reduce LGBTQ-related bias among medical, nursing, and dental students and providers: a systematic review](#)
- American Psychological Association: CE - How does implicit bias by physicians affect patients' health care?
- Joint Commission: [Implicit bias in health care](#)
- StratisHealth: [Implicit Bias in Health Care (Quiz)](#)
# AGENDA REQUEST FORM

1) Name and title of person submitting the request:  
Valerie Payne, Executive Director

2) Date when request submitted:  
12/10/19

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:  
12/18/19

5) Attachments:  
☑ Yes  
☐ No

6) How should the item be titled on the agenda page?  
Legislative and Policy Matters – Discussion and Consideration

1. LRB-0196/2 Relating to regulation of physician assistants, creating a Physician Assistant Examining Board, extending the time limit for emergency rule procedures, providing an exemption from emergency rule procedures, granting rule-making authority, and providing a penalty

7) Place Item in:  
☑ Open Session  
☐ Closed Session

8) Is an appearance before the Board being scheduled? (If yes, please complete Appearance Request for Non-DSPS Staff)  
Yes  
☒ No

9) Name of Case Advisor(s), if required:  
n/a

10) Describe the issue and action that should be addressed:  
Review and discuss the LRB-0196/2 draft and how other drafts may effect publication of this bill.

11) Authorization  
Valerie Payne  
12/10/19

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.
AN ACT to repeal 15.407 (2), 50.01 (4p), 252.01 (5), 448.01 (6), 448.03 (1) (b),
448.03 (3) (e), 448.04 (1) (f), 448.05 (5), 448.20, 448.21, 448.40 (2) (f), 448.695 (4)
and 450.01 (15r); to renumber 448.038; to amend 15.08 (1m) (b), 16.417 (1)
(e) 3m., 46.03 (44), 48.981 (2m) (b) 1., 49.45 (9r) (a) 7. a., 50.08 (2), 50.39 (3),
50.60 (1), 55.14 (8) (b), 69.01 (6g), 70.47 (8) (intro.), 97.67 (5m) (a) 3., 118.2925
(1) (f), 146.38 (1) (b) 1., 146.81 (1) (d), 146.81 (1) (i), 146.81 (1) (j), 146.82 (3) (a),
146.89 (1) (r) 1., 146.997 (1) (d) 5., 155.01 (7), 252.15 (1) (am), 252.15 (1) (ar) 1.,
255.07 (1) (d), 255.07 (7), 257.01 (5) (a), 257.01 (5) (b), 343.16 (5) (a), 440.035
(2m) (b), 440.035 (2m) (c) 1. (intro.), 440.015 (4) (am) 2., 440.02 (1), 448.03 (2)
(a), 448.03 (2) (e), 448.03 (2) (k), 448.03 (5) (b), 448.035 (2) to (4), 448.037 (2) (a)
(intro.) and (b) and (3), 448.62 (7), 450.01 (16) (hm) 3., 450.10 (3) (a) 5., 450.11
(1), 450.11 (1g) (b), 450.11 (1i) (a) 1., 450.11 (1i) (b) 2. c., 450.11 (1i) (c) 2., 450.11
(8) (b), 462.02 (2) (e), 462.04, 895.48 (1m) (a) (intro.), 961.01 (19) (a) and 971.14
(4) (a); and to create 15.405 (4), 49.45 (9r) (a) 7. am., 69.18 (1) (ck), 146.81 (1)
BILL

1. (hr), 146.997 (1) (d) 13m., 180.1901 (1m) (h), 450.10 (3) (a) 12., 450.11 (1i) (b) 2.
2. cm., 450.11 (8) (f), chapter 461 and 990.01 (27s) of the statutes; relating to:
3. regulation of physician assistants, creating a Physician Assistant Examining
4. Board, extending the time limit for emergency rule procedures, providing an
5. exemption from emergency rule procedures, granting rule-making authority,
6. and providing a penalty.

Analysis by the Legislative Reference Bureau

This bill makes changes with respect to the licensure, regulation, and practice of physician assistants (PAs).

Under current law, PAs are defined as individuals who are licensed to provide medical care with physician supervision and direction. The Medical Examining Board licenses and regulates PAs as well as physicians and certain other professions. The Medical Examining Board is composed of ten physicians and three public members and is authorized to promulgate rules establishing licensing and practice standards for PAs.

This bill transfers licensure and regulation of PAs to the newly created Physician Assistant Examining Board. The new board is composed of seven PAs, one member who may be either a physician or a PA, and one public member. In addition, the bill makes various changes to the licensure, regulation, and practice of PAs, including all of the following:

1. Instead of requiring that a PA practice under the supervision and direction of a physician, requires, subject to certain exceptions, that a PA who provides care to patients maintain and provide to the board upon request either 1) evidence that, pursuant to the physician assistant's employment, there is a physician who is primarily responsible for the overall direction and management of the physician assistant's professional activities and for assuring that the services provided by the physician assistant are medically appropriate or 2) a written collaborative agreement with a physician or, if the physician assistant's practice is limited to the practice of podiatry, a podiatrist, which must describe the PA's scope of practice and include other information as required by the board. However, the bill provides that a PA is individually and independently responsible for the quality of the care he or she renders.

2. Defines a PA's practice similarly to the definition of the practice of medicine and surgery. The bill also explicitly provides that a PA may prescribe, dispense, and administer drugs and may serve as a primary or specialty care provider. The bill requires a PA to limit his or her practice to the scope of his or her experience, education, and training, and retains a number of limitations on the practice of PAs.

3. Includes a number of additional provisions with respect to the obligations of PAs. These include a requirement that a PA have in effect malpractice liability
insurance coverage when practicing, subject to certain exceptions and other provisions.

4. Establishes licensure requirements for PAs, which differ in a number of respects from the requirements under current law, including that PAs submit additional information, including an employment history, with a licensure application. Under the bill, the board must require continuing education for PAs. Currently, PAs are not required to complete continuing education.

5. Specifies various grounds for professional discipline of a PA by the board and allows the board to impose professional discipline consistent with other professions. Because this bill creates a new crime or revises a penalty for an existing crime, the Joint Review Committee on Criminal Penalties may be requested to prepare a report.

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

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

SECTION 1. 15.08 (1m) (b) of the statutes is amended to read:

15.08 (1m) (b) The public members of the chiropractic examining board, the dentistry examining board, the hearing and speech examining board, the medical examining board, the physical therapy examining board, the perfusionists examining council, the respiratory care practitioners examining council and council on the physician assistants assistant examining board, the board of nursing, the nursing home administrator examining board, the veterinary examining board, the optometry examining board, the pharmacy examining board, the marriage and family therapy, professional counseling, and social work examining board, the psychology examining board, and the radiography examining board shall not be engaged in any profession or occupation concerned with the delivery of physical or mental health care.

SECTION 2. 15.405 (4) of the statutes is created to read:
15.405 (4) **PHYSICIAN ASSISTANT EXAMINING BOARD.** (a) There is created in the
department of safety and professional services a physician assistant examining
board consisting of the following members appointed for staggered 4-year terms:

1. Seven physician assistants licensed under ch. 461.

2. One individual who is either a physician licensed under subch. II of ch. 448
or a physician assistant licensed under ch. 461.

3. One public member.

(b) The governor may appoint a physician assistant to the physician assistant
examining board under par. (a) 2. only if the governor has determined that there is
no suitable physician who is willing to serve on the board.

**SECTION 3.** 15.407 (2) of the statutes is repealed.

**SECTION 4.** 16.417 (1) (e) 3m. of the statutes is amended to read:

16.417 (1) (e) 3m. A physician assistant who is licensed under s. 448.04 (1) (f)
461.07.

**SECTION 5.** 46.03 (44) of the statutes is amended to read:

46.03 (44) **SEXUALLY TRANSMITTED DISEASE TREATMENT INFORMATION.** Prepare and
keep current an information sheet to be distributed to a patient by a physician,
physician assistant, or certified advanced practice nurse prescriber providing
expedited partner therapy to that patient under s. 448.035 or 461.035. The
information sheet shall include information about sexually transmitted diseases and
their treatment and about the risk of drug allergies. The information sheet shall also
include a statement advising a person with questions about the information to
contact his or her physician, pharmacist, or local health department, as defined in
s. 250.01 (4).

**SECTION 6.** 48.981 (2m) (b) 1. of the statutes is amended to read:
BILL

48.981 (2m) (b) 1. “Health care provider” means a physician, as defined under s. 448.01 (5), a physician assistant, as defined under s. 448.01 (6), 461.01 (3), or a nurse holding a license under s. 441.06 (1) or a license under s. 441.10.

SECTION 7. 49.45 (9r) (a) 7. a. of the statutes is amended to read:

49.45 (9r) (a) 7. a. A physician or physician assistant licensed under subch. II of ch. 448.

SECTION 8. 49.45 (9r) (a) 7. am. of the statutes is created to read:

49.45 (9r) (a) 7. am. A physician assistant licensed under ch. 461.

SECTION 9. 50.01 (4p) of the statutes is repealed.

SECTION 10. 50.08 (2) of the statutes is amended to read:

50.08 (2) A physician, an advanced practice nurse prescriber certified under s. 441.16 (2), or a physician assistant licensed under ch. 448, who prescribes a psychotropic medication to a nursing home resident who has degenerative brain disorder shall notify the nursing home if the prescribed medication has a boxed warning under 21 CFR 201.57.

SECTION 11. 50.39 (3) of the statutes is amended to read:

50.39 (3) Facilities governed by ss. 45.50, 48.62, 49.70, 49.72, 50.02, 51.09, and 252.10, juvenile correctional facilities as defined in s. 938.02 (10p), correctional institutions governed by the department of corrections under s. 301.02, and the offices and clinics of persons licensed to treat the sick under chs. 446, 447, and 448 are exempt from ss. 50.32 to 50.39. Sections 50.32 to 50.39 do not abridge the rights of the medical examining board, physician assistant examining board, physical therapy examining board, podiatry affiliated credentialing board, dentistry examining board, pharmacy examining board, chiropractic examining board, and board of nursing in carrying out their statutory duties and responsibilities.
SECTION 12. 50.60 (1) of the statutes is amended to read:

50.60 (1) “Health care provider” has the meaning given in s. 146.81 (1) (a) to (hp) (hr).

SECTION 13. 55.14 (8) (b) of the statutes is amended to read:

55.14 (8) (b) Order the individual to comply with the treatment plan under par. (a). The order shall provide that if the individual fails to comply with provisions of the treatment plan that require the individual to take psychotropic medications, the medications may be administered involuntarily with consent of the guardian. The order shall specify the methods of involuntary administration of psychotropic medication to which the guardian may consent. An order authorizing the forcible restraint of an individual shall specify that a person licensed under s. 441.06, 441.10, or 448.05 (2) or (5), or 461.07 shall be present at all times that psychotropic medication is administered in this manner and shall require the person or facility using forcible restraint to maintain records stating the date of each administration, the medication administered, and the method of forcible restraint utilized.

SECTION 14. 69.01 (6g) of the statutes is amended to read:

69.01 (6g) “Date of death” means the date that a person is pronounced dead by a physician, coroner, deputy coroner, medical examiner, deputy medical examiner, physician assistant, or hospice nurse.

SECTION 15. 69.18 (1) (ck) of the statutes is created to read:

69.18 (1) (ck) For purposes of preparation of the certificate of death and in accordance with accepted medical standards, a physician assistant who is directly involved with the care of a patient who dies may pronounce the date, time, and place of the patient’s death.

SECTION 16. 70.47 (8) (intro.) of the statutes is amended to read:
70.47 (8) HEARING. (intro.) The board shall hear upon oath all persons who appear before it in relation to the assessment. Instead of appearing in person at the hearing, the board may allow the property owner, or the property owner’s representative, at the request of either person, to appear before the board, under oath, by telephone or to submit written statements, under oath, to the board. The board shall hear upon oath, by telephone, all ill or disabled persons who present to the board a letter from a physician, osteopath, physician assistant, as defined in s. 448.01 (6), or advanced practice nurse prescriber certified under s. 441.16 (2) that confirms their illness or disability. At the request of the property owner or the property owner’s representative, the board may postpone and reschedule a hearing under this subsection, but may not postpone and reschedule a hearing more than once during the same session for the same property. The board at such hearing shall proceed as follows:

SECTION 17. 97.67 (5m) (a) 3. of the statutes is amended to read:

97.67 (5m) (a) 3. A physician assistant licensed under subch. II of ch. 448 461.

SECTION 18. 118.2925 (1) (f) of the statutes is amended to read:

118.2925 (1) (f) “Physician assistant” means a person licensed under s. 448.04 (1) (f) 461.07.

SECTION 19. 146.38 (1) (b) 1. of the statutes is amended to read:

146.38 (1) (b) 1. A person specified in s. 146.81 (1) (a) to (hr), (r), or (s).

SECTION 20. 146.81 (1) (d) of the statutes is amended to read:

146.81 (1) (d) A physician, physician assistant, perfusionist, or respiratory care practitioner licensed or certified under subch. II of ch. 448.

SECTION 21. 146.81 (1) (hr) of the statutes is created to read:

146.81 (1) (hr) A physician assistant licensed under ch. 461.
SECTION 22. 146.81 (1) (i) of the statutes is amended to read:

146.81 (1) (i) A partnership of any providers specified under pars. (a) to (hp) (hr).

SECTION 23. 146.81 (1) (j) of the statutes is amended to read:

146.81 (1) (j) A corporation or limited liability company of any providers specified under pars. (a) to (hp) (hr) that provides health care services.

SECTION 24. 146.82 (3) (a) of the statutes is amended to read:

146.82 (3) (a) Notwithstanding sub. (1), a physician, physician assistant, as defined in s. 448.01 (6), or advanced practice nurse prescriber certified under s. 441.16 (2) who treats a patient whose physical or mental condition in the physician’s, physician assistant’s, or advanced practice nurse prescriber’s judgment affects the patient’s ability to exercise reasonable and ordinary control over a motor vehicle may report the patient’s name and other information relevant to the condition to the department of transportation without the informed consent of the patient.

SECTION 25. 146.89 (1) (r) 1. of the statutes is amended to read:

146.89 (1) (r) 1. Licensed as a physician under ch. 448, a dentist or dental hygienist under ch. 447, a registered nurse, practical nurse, or nurse–midwife under ch. 441, an optometrist under ch. 449, a physician assistant under ch. 448, a pharmacist under ch. 450, a chiropractor under ch. 446, a podiatrist under subch. IV of ch. 448, or a physical therapist under subch. III of ch. 448.

SECTION 26. 146.997 (1) (d) 5. of the statutes is amended to read:

146.997 (1) (d) 5. An occupational therapist, occupational therapy assistant, physician assistant or respiratory care practitioner licensed or certified under ch. 448.

SECTION 27. 146.997 (1) (d) 13m. of the statutes is created to read:
BILL

146.997 (1) (d) 13m. A physician assistant licensed under ch. 461.

SECTION 28. 155.01 (7) of the statutes is amended to read:

155.01 (7) “Health care provider” means a nurse licensed or permitted under ch. 441, a chiropractor licensed under ch. 446, a dentist licensed under ch. 447, a physician, physician assistant, perfusionist, podiatrist, physical therapist, physical therapist assistant, occupational therapist, or occupational therapy assistant licensed under ch. 448, a person practicing Christian Science treatment, an optometrist licensed under ch. 449, a psychologist licensed under ch. 455, a physician assistant licensed under ch. 461, a partnership thereof, a corporation or limited liability company thereof that provides health care services, a cooperative health care association organized under s. 185.981 that directly provides services through salaried employees in its own facility, or a home health agency, as defined in s. 50.49 (1) (a).

SECTION 29. 180.1901 (1m) (h) of the statutes is created to read:

180.1901 (1m) (h) Physician assistant examining board under ch. 461.

SECTION 30. 252.01 (5) of the statutes is repealed.

SECTION 31. 252.15 (1) (am) of the statutes is amended to read:

252.15 (1) (am) “Health care professional” means a physician or physician assistant who is licensed under ch. 448 or, a registered nurse or licensed practical nurse who is licensed under ch. 441, or a physician assistant licensed under ch. 461.

SECTION 32. 252.15 (1) (ar) 1. of the statutes is amended to read:

252.15 (1) (ar) 1. A person or entity that is specified in s. 146.81 (1) (a) to (hm), (hr), and (i) to (p).

SECTION 33. 255.07 (1) (d) of the statutes is amended to read:
255.07 (1) (d) “Health care practitioner” means a physician, a physician assistant licensed under s. 448.04 (1) (f), or an advanced practice nurse who is certified to issue prescription orders under s. 441.16.

SECTION 34. 255.07 (7) of the statutes is amended to read:

255.07 (7) HEALTH CARE PROVIDERS. Nothing in this section prohibits a health care provider, as defined in s. 146.81 (1) (a) to (hp) (hr) and (q) to (s), from acting within the scope of practice of the health care provider’s license, certificate, permit, or registration.

SECTION 35. 257.01 (5) (a) of the statutes is amended to read:

257.01 (5) (a) An individual who is licensed as a physician, a physician assistant, or a podiatrist under ch. 448, licensed as a registered nurse, licensed practical nurse, or nurse-midwife under ch. 441, licensed as a dentist under ch. 447, licensed as a pharmacist under ch. 450, licensed as a physician assistant under ch. 461, licensed as a veterinarian or certified as a veterinary technician under ch. 89, or certified as a respiratory care practitioner under ch. 448.

SECTION 36. 257.01 (5) (b) of the statutes is amended to read:

257.01 (5) (b) An individual who was at any time within the previous 10 years, but is not currently, licensed as a physician, a physician assistant, or a podiatrist under ch. 448, licensed as a registered nurse, licensed practical nurse or nurse-midwife, under ch. 441, licensed as a dentist under ch. 447, licensed as a pharmacist under ch. 450, licensed as a physician assistant under ch. 461 or as a physician assistant under ch. 448, 2017 stats., licensed as a veterinarian or certified as a veterinary technician under ch. 89, or certified as a respiratory care practitioner under ch. 448, if the individual’s license or certification was never revoked, limited, suspended, or denied renewal.
SECTION 37. 343.16 (5) (a) of the statutes is amended to read:

343.16 (5) (a) The secretary may require any applicant for a license or any licensed operator to submit to a special examination by such persons or agencies as the secretary may direct to determine incompetency, physical or mental disability, disease, or any other condition that might prevent such applicant or licensed person from exercising reasonable and ordinary control over a motor vehicle. If the department requires the applicant to submit to an examination, the applicant shall pay for the examination. If the department receives an application for a renewal or duplicate license after voluntary surrender under s. 343.265 or receives a report from a physician, physician assistant, as defined in s. 448.01 (6), advanced practice nurse prescriber certified under s. 441.16 (2), or optometrist under s. 146.82 (3), or if the department has a report of 2 or more arrests within a one-year period for any combination of violations of s. 346.63 (1) or (5) or a local ordinance in conformity with s. 346.63 (1) or (5) or a law of a federally recognized American Indian tribe or band in this state in conformity with s. 346.63 (1) or (5), or s. 346.63 (1m), 1985 stats., or s. 346.63 (2) or (6) or 940.25, or s. 940.09 where the offense involved the use of a vehicle, the department shall determine, by interview or otherwise, whether the operator should submit to an examination under this section. The examination may consist of an assessment. If the examination indicates that education or treatment for a disability, disease or condition concerning the use of alcohol, a controlled substance or a controlled substance analog is appropriate, the department may order a driver safety plan in accordance with s. 343.30 (1q). If there is noncompliance with assessment or the driver safety plan, the department shall revoke the person’s operating privilege in the manner specified in s. 343.30 (1q) (d).

SECTION 38. 440.035 (2m) (b) of the statutes is amended to read:
440.035 (2m) (b) The medical examining board, the physician assistant examining board, the podiatry affiliated credentialing board, the board of nursing, the dentistry examining board, or the optometry examining board may issue guidelines regarding best practices in prescribing controlled substances for persons credentialed by that board who are authorized to prescribe controlled substances.

SECTION 39. 440.035 (2m) (c) 1. (intro.) of the statutes is amended to read:

440.035 (2m) (c) 1. (intro.) The medical examining board, the physician assistant examining board, the podiatry affiliated credentialing board, the board of nursing, the dentistry examining board, and the optometry examining board shall, by November 1, 2018, and annually thereafter of each year, submit a report to the persons specified in subd. 2. that does all of the following:

SECTION 40. 448.01 (6) of the statutes is repealed.

SECTION 41. 448.015 (4) (am) 2. of the statutes is amended to read:

448.015 (4) (am) 2. Any act by a physician or physician assistant in violation of ch. 450 or 961.

SECTION 42. 448.02 (1) of the statutes is amended to read:

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

SECTION 43. 448.03 (1) (b) of the statutes is repealed.

SECTION 44. 448.03 (2) (a) of the statutes is amended to read:

448.03 (2) (a) Any person lawfully practicing within the scope of a license, permit, registration, certificate or certification granted to practice midwifery under subch. XIII of ch. 440, to practice professional or practical nursing or
nurse-midwifery under ch. 441, to practice chiropractic under ch. 446, to practice
dentistry or dental hygiene under ch. 447, to practice optometry under ch. 449, to
practice acupuncture under ch. 451 or under any other statutory provision, to
practice as a physician assistant under ch. 461, or as otherwise provided by statute.

**SECTION 45.** 448.03 (2) (e) of the statutes is amended to read:

> 448.03 (2) (e) Any person other than a physician assistant or an
> anesthesiologist assistant who is providing patient services as directed, supervised
> and inspected by a physician who has the power to direct, decide and oversee the
> implementation of the patient services rendered.

**SECTION 46.** 448.03 (2) (k) of the statutes is amended to read:

> 448.03 (2) (k) Any persons, other than physician assistants, anesthesiologist
> assistants, or perfusionists, who assist physicians.

**SECTION 47.** 448.03 (3) (e) of the statutes is repealed.

**SECTION 48.** 448.03 (5) (b) of the statutes is amended to read:

> 448.03 (5) (b) No physician or physician assistant shall be liable for any civil
> damages for either of the following:

1. Reporting in good faith to the department of transportation under s. 146.82
(3) a patient’s name and other information relevant to a physical or mental condition
of the patient which in the physician’s or physician assistant’s judgment impairs the
patient’s ability to exercise reasonable and ordinary control over a motor vehicle.

2. In good faith, not reporting to the department of transportation under s.
146.82 (3) a patient’s name and other information relevant to a physical or mental
condition of the patient which in the physician’s or physician assistant’s judgment
does not impair the patient’s ability to exercise reasonable and ordinary control over
a motor vehicle.
SECTION 49. 448.035 (2) to (4) of the statutes are amended to read:

448.035 (2) Notwithstanding the requirements of s. 448.30, a physician, physician assistant, or certified advanced practice nurse prescriber may provide expedited partner therapy if the patient is diagnosed as infected with a chlamydial infection, gonorrhea, or trichomoniasis and the patient has had sexual contact with a sexual partner during which the chlamydial infection, gonorrhea, or trichomoniasis may have been transmitted to or from the sexual partner. The physician, physician assistant, or certified advanced practice nurse prescriber shall attempt to obtain the name of the patient’s sexual partner. A prescription order for an antimicrobial drug prepared under this subsection shall include the name and address of the patient’s sexual partner, if known. If the physician, physician assistant, or certified advanced practice nurse prescriber is unable to obtain the name of the patient’s sexual partner, the prescription order shall include, in ordinary bold-faced capital letters, the words, “expedited partner therapy” or the letters “EPT.”

(3) The physician, physician assistant, or certified advanced practice nurse prescriber shall provide the patient with a copy of the information sheet prepared by the department of health services under s. 46.03 (44) and shall request that the patient give the information sheet to the person with whom the patient had sexual contact.

(4) (a) Except as provided in par. (b), a physician, physician assistant, or certified advanced practice nurse prescriber is immune from civil liability for injury to or the death of a person who takes any antimicrobial drug if the antimicrobial drug is prescribed, dispensed, or furnished under this section and if expedited partner therapy is provided as specified under this section.
(b) The immunity under par. (a) does not extend to the donation, distribution, furnishing, or dispensing of an antimicrobial drug by a physician, physician assistant, or certified advanced practice nurse prescriber whose act or omission involves reckless, wanton, or intentional misconduct.

SECTION 50. 448.037 (2) (a) (intro.) and (b) and (3) of the statutes are amended to read:

448.037 (2) (a) (intro.) A physician or physician assistant may do any of the following:

(b) A physician or physician assistant who prescribes or delivers an opioid antagonist under par. (a) 1. shall ensure that the person to whom the opioid antagonist is prescribed has or has the capacity to provide the knowledge and training necessary to safely administer the opioid antagonist to an individual undergoing an opioid-related overdose and that the person demonstrates the capacity to ensure that any individual to whom the person further delivers the opioid antagonist has or receives that knowledge and training.

(3) A physician or physician assistant who, acting in good faith, prescribes or delivers an opioid antagonist in accordance with sub. (2), or who, acting in good faith, otherwise lawfully prescribes or dispenses an opioid antagonist, shall be immune from criminal or civil liability and may not be subject to professional discipline under s. 448.02 for any outcomes resulting from prescribing, delivering, or dispensing the opioid antagonist.

SECTION 51. 448.038 of the statutes is renumbered 461.038.

SECTION 52. 448.04 (1) (f) of the statutes is repealed.

SECTION 53. 448.05 (5) of the statutes is repealed.

SECTION 54. 448.20 of the statutes is repealed.
SECTION 55. 448.21 of the statutes is repealed.

SECTION 56. 448.40 (2) (f) of the statutes is repealed.

SECTION 57. 448.62 (7) of the statutes is amended to read:

448.62 (7) A physician assistant who is acting under the supervision and direction of in collaboration with a podiatrist, subject to s. 448.21 (4) as described in s. 461.10 (2) (a) 1. c. or an individual to whom the physician assistant delegates a task or order under s. 461.10 (4).

SECTION 58. 448.695 (4) of the statutes is repealed.

SECTION 59. 450.01 (15r) of the statutes is repealed.

SECTION 60. 450.01 (16) (hm) 3. of the statutes is amended to read:

450.01 (16) (hm) 3. The patient’s physician assistant, if the physician assistant is under the supervision of the patient’s personal attending physician.

SECTION 61. 450.10 (3) (a) 5. of the statutes is amended to read:

450.10 (3) (a) 5. A physician, physician assistant, podiatrist, physical therapist, physical therapist assistant, occupational therapist, or occupational therapy assistant licensed under ch. 448.

SECTION 62. 450.10 (3) (a) 12. of the statutes is created to read:

450.10 (3) (a) 12. A physician assistant licensed under ch. 461.

SECTION 63. 450.11 (1) of the statutes is amended to read:

450.11 (1) DISPENSING. Except as provided in sub. (1i) (b) 2., no person may dispense any prescribed drug or device except upon the prescription order of a practitioner. All prescription orders shall, except as provided in sub. (1a), specify the date of issue, the name and address of the practitioner, the name and quantity of the drug product or device prescribed, directions for the use of the drug product or device, the symptom or purpose for which the drug is being prescribed if required under sub.
(4) (a) 8., and, if the order is written by the practitioner, the signature of the practitioner. Except as provided in ss. 118.2925 (3), 255.07 (2), 441.18 (2) (a) 1., 448.035 (2), and 448.037 (2) (a) 1., 461.035 (2), and 461.037 (2) (a) 1., and except for standing orders issued under s. 441.18 (2) (a) 2. or 448.037 (2) (a) 2., or 461.037 (2) (a) 2., all prescription orders shall also specify the name and address of the patient. A prescription order issued under s. 118.2925 (3) shall specify the name and address of the school. A prescription order issued under s. 255.07 (2) shall specify the name and address of the authorized entity or authorized individual. Any oral prescription order shall be immediately reduced to writing by the pharmacist and filed according to sub. (2).

SECTION 64. 450.11 (1g) (b) of the statutes is amended to read:

450.11 (1g) (b) A pharmacist may, upon the prescription order of a practitioner providing expedited partner therapy, as specified in s. 448.035 or 461.035, that complies with the requirements of sub. (1), dispense an antimicrobial drug as a course of therapy for treatment of chlamydial infections, gonorrhea, or trichomoniasis to the practitioner’s patient or a person with whom the patient has had sexual contact for use by the person with whom the patient has had sexual contact. The pharmacist shall provide a consultation in accordance with rules promulgated by the board for the dispensing of a prescription to the person to whom the antimicrobial drug is dispensed. A pharmacist providing a consultation under this paragraph shall ask whether the person for whom the antimicrobial drug has been prescribed is allergic to the antimicrobial drug and advise that the person for whom the antimicrobial drug has been prescribed must discontinue use of the antimicrobial drug if the person is allergic to or develops signs of an allergic reaction to the antimicrobial drug.
SECTION 65. 450.11 (1i) (a) 1. of the statutes is amended to read:

450.11 (1i) (a) 1. A pharmacist may, upon and in accordance with the prescription order of an advanced practice nurse prescriber under s. 441.18 (2) (a) 1., or of a physician or physician assistant under s. 448.037 (2) (a) 1., or of a physician assistant under s. 461.037 (2) (a) 1. that complies with the requirements of sub. (1), deliver an opioid antagonist to a person specified in the prescription order and may, upon and in accordance with the standing order of an advanced practice nurse prescriber under s. 441.18 (2) (a) 2., or of a physician or physician assistant under s. 448.037 (2) (a) 2., or of a physician assistant under s. 461.037 (2) (a) 2. that complies with the requirements of sub. (1), deliver an opioid antagonist to an individual in accordance with the order. The pharmacist shall provide a consultation in accordance with rules promulgated by the board for the delivery of a prescription to the person to whom the opioid antagonist is delivered.

SECTION 66. 450.11 (1i) (b) 2. c. of the statutes is amended to read:

450.11 (1i) (b) 2. c. A physician or physician assistant may only deliver or dispense an opioid antagonist in accordance with s. 448.037 (2) or in accordance with his or her other legal authority to dispense prescription drugs.

SECTION 67. 450.11 (1i) (b) 2. cm. of the statutes is created to read:

450.11 (1i) (b) 2. cm. A physician assistant may only deliver or dispense an opioid antagonist in accordance with s. 461.037 (2) or in accordance with his or her other legal authority to dispense prescription drugs.

SECTION 68. 450.11 (1i) (c) 2. of the statutes is amended to read:

450.11 (1i) (c) 2. Subject to par. (a) 2. and ss. 441.18 (3) and 448.037 (3), and 461.037 (3), any person who, acting in good faith, delivers or dispenses an opioid
antagonist to another person shall be immune from civil or criminal liability for any outcomes resulting from delivering or dispensing the opioid antagonist.

SECTION 69. 450.11 (8) (b) of the statutes is amended to read:

450.11 (8) (b) The medical examining board, insofar as this section applies to physicians and physician assistants.

SECTION 70. 450.11 (8) (f) of the statutes is created to read:

450.11 (8) (f) The physician assistant examining board, insofar as this section applies to physician assistants.

SECTION 71. Chapter 461 of the statutes is created to read:

CHAPTER 461

PHYSICIAN ASSISTANTS

461.01 Definitions. In this chapter, unless the context requires otherwise:

(1) “Board” means the physician assistant examining board.

(2) “Disease” means any pain, injury, deformity, or physical or mental illness or departure from complete health or the proper condition of the human body or any of its parts.

(3) “Physician assistant” means a person licensed under this chapter.

(4) “Podiatrist” has the meaning given in s. 448.60 (3).

(5) “Podiatry” has the meaning given in s. 448.60 (4).

(6) “Practice of medicine and surgery” has the meaning given in s. 448.01 (9).

461.03 License required; exceptions. (1) Except as provided in subs. (2) and (3), no person may represent himself or herself as a “PA,” “physician assistant,” “physician associate,” or “associate physician,” use or assume the title “PA,” “physician assistant,” “physician associate,” or “associate physician,” or append to the person’s name the words or letters “physician assistant,” “physician associate,”
“associate physician,” “PA,” “PA-C,” or any other titles, letters, or designation that represents or may tend to represent the person as a physician assistant, unless he or she is licensed by the board under this chapter.

(2) Subsection (1) does not apply with respect to any of the following:

(a) An individual employed and duly credentialed as a physician assistant or physician associate by the federal government while performing duties incident to that employment, unless a license under this chapter is required by the federal government.

(b) A person who satisfies the requirement under s. 461.07 (1) (a) 3. but who is not licensed under this chapter. This paragraph does not allow such a person to practice medicine and surgery in violation of s. 448.03 (1) (a) or to practice podiatry in violation of s. 448.61.

(3) A student who is enrolled in an accredited physician assistant educational program may use the title “physician assistant student,” “PA student,” or “PA-S.”

461.035 Expedited partner therapy. (1) In this section:

(b) “Antimicrobial drug” has the meaning given in s. 448.035 (1) (b).

(c) “Expedited partner therapy” has the meaning given in s. 448.035 (1) (c).

(2) Notwithstanding the requirements of s. 461.40, a physician assistant may provide expedited partner therapy if a patient is diagnosed as infected with a chlamydial infection, gonorrhea, or trichomoniasis and the patient has had sexual contact with a sexual partner during which the chlamydial infection, gonorrhea, or trichomoniasis may have been transmitted to or from the sexual partner. The physician assistant shall attempt to obtain the name of the patient’s sexual partner. A prescription order for an antimicrobial drug prepared under this subsection shall include the name and address of the patient’s sexual partner, if known. If the
physician assistant is unable to obtain the name of the patient’s sexual partner, the prescription order shall include, in ordinary, bold-faced capital letters, the words, “expedited partner therapy” or the letters “EPT.”

(3) The physician assistant shall provide the patient with a copy of the information sheet prepared by the department of health services under s. 46.03 (44) and shall request that the patient give the information sheet to the person with whom the patient had sexual contact.

(4) (a) Except as provided in par. (b), a physician assistant is immune from civil liability for injury to or the death of a person who takes any antimicrobial drug if the antimicrobial drug is prescribed, dispensed, or furnished under this section and if expedited partner therapy is provided as specified under this section.

(b) The immunity under par. (a) does not extend to the donation, distribution, furnishing, or dispensing of an antimicrobial drug by a physician assistant whose act or omission involves reckless, wanton, or intentional misconduct.

461.037 Prescriptions for and delivery of opioid antagonists. (1) In this section:

(a) “Administer” has the meaning given in s. 450.01 (1).

(b) “Deliver” has the meaning given in s. 450.01 (5).

(c) “Dispense” has the meaning given in s. 450.01 (7).

(d) “Opioid antagonist” has the meaning given in s. 450.01 (13v).

(e) “Opioid–related drug overdose” has the meaning given in s. 256.40 (1) (d).

(f) “Standing order” has the meaning given in s. 450.01 (21p).

(2) (a) A physician assistant may do any of the following:

1. Prescribe an opioid antagonist to a person in a position to assist an individual at risk of undergoing an opioid–related drug overdose and may deliver the opioid
antagonist to that person. A prescription order under this subdivision need not specify the name and address of the individual to whom the opioid antagonist will be administered, but shall instead specify the name of the person to whom the opioid antagonist is prescribed.

2. Issue a standing order to one or more persons authorizing the dispensing of an opioid antagonist.

(b) A physician assistant who prescribes or delivers an opioid antagonist under par. (a) 1. shall ensure that the person to whom the opioid antagonist is prescribed has or has the capacity to provide the knowledge and training necessary to safely administer the opioid antagonist to an individual undergoing an opioid-related overdose and that the person demonstrates the capacity to ensure that any individual to whom the person further delivers the opioid antagonist has or receives that knowledge and training.

(3) A physician assistant who, acting in good faith, prescribes or delivers an opioid antagonist in accordance with sub. (2) or who, acting in good faith, otherwise lawfully prescribes or dispenses an opioid antagonist shall be immune from criminal or civil liability and may not be subject to professional discipline under s. 461.30 for any outcomes resulting from prescribing, delivering, or dispensing the opioid antagonist.

461.05 Powers and duties of board. (1) (a) The board shall promulgate rules implementing s. 461.40.

(b) The board shall promulgate rules establishing continuing education requirements for physician assistants.

(c) The board may promulgate other rules to carry out the purposes of this chapter, including any of the following:
1. Rules defining what constitutes unprofessional conduct for physician assistants for purposes of s. 461.30 (2) (d).

2. Rules under s. 461.12 (2).

(2) The board shall include in the register the board maintains under s. 440.035 (1m) (d) the names of all persons whose licenses issued under this chapter were suspended or revoked within the past 2 years. The register shall be available for purchase at cost.

461.07 License; renewal. (1) (a) Except as provided in par. (b), the board shall grant an initial license to practice as a physician assistant to any applicant who is found qualified by three-fourths of the members of the board and satisfies all of the following requirements, as determined by the board:

1. The applicant submits an application on a form provided by the department and pays the initial credential fee determined by the department under s. 440.03 (9) (a).

2. The applicant is at least 18 years of age.

3. The applicant provides evidence of one of the following:

a. That the applicant has successfully completed an educational program for physician assistants or physician associates that is accredited by the Accreditation Review Commission on Education for the Physician Assistant or its successor or, prior to 2001, by the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs.

b. If the applicant does not satisfy subd. 3. a., that the applicant, prior to January 1, 1986, successfully passed the Physician Assistant National Certifying Examination administered by the National Commission on Certification of Physician Assistants.
4. The applicant passes the National Commission on Certification of Physician Assistants examination or an equivalent national examination adopted by the board.

5. The applicant provides a listing with all employers, practice settings, internships, residencies, fellowships, and other employment for the past 7 years.

6. Subject to ss. 111.321, 111.322, and 111.335, the applicant does not have an arrest or conviction record.

(b) Paragraph (a) 3. does not apply to an applicant if the applicant provides evidence that he or she is licensed as a physician assistant or physician associate in another state, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction of the United States and the board determines that the requirements for obtaining the license in that state or territory are substantially equivalent to the requirements under par. (a).

(2) (a) The renewal date for a license issued under this chapter is specified under s. 440.08 (2) (a), and the renewal fees for such licenses are determined by the department under s. 440.03 (9) (a). Renewal of a license is subject to par. (b).

(b) An applicant for the renewal of a license under this chapter shall submit with his or her application for renewal proof of having satisfied the continuing education requirements imposed by the board under s. 461.05 (1) (b). This paragraph does not apply to an applicant for renewal of a license that expires on the first renewal date after the date on which the board initially granted the license.

(3) Notwithstanding sub. (1), an individual who, on the effective date of this subsection .... [LRB inserts date], was licensed by the medical examining board as a physician assistant under subch. II of ch. 448, 2017 stats., shall be considered to have been licensed under sub. (1) for purposes of this chapter.
461.10 Practice and employment. (1) (a) Subject to the limitations and requirements under sub. (2); the physician assistant’s experience, education, and training; and any rules promulgated under sub. (5), a physician assistant may do any of the following:

1. Examine into the fact, condition, or cause of human health or disease, or treat, operate, prescribe, or advise for the same, by any means or instrumentality.

2. Apply principles or techniques of medical sciences in the diagnosis or prevention of any of the conditions described in subd. 1. and in s. 461.01 (2).

3. Penetrate, pierce, or sever the tissues of a human being.

4. Offer, undertake, attempt, or hold oneself out in any manner as able to do any of the acts described in this paragraph.

(b) Subject to any rules promulgated by the board and consistent with his or her experience, education, and training, a physician assistant may order, prescribe, procure, dispense, and administer prescription drugs, medical devices, services, and supplies.

(c) A physician assistant may practice in ambulatory care, acute care, long-term care, home care, or other settings as a primary, specialty, or surgical care provider who may serve as a patient’s primary care provider or specialty care provider.

(2) (a) 1. Except as provided in subd. 3. and sub. (5) (a) or (b), a physician assistant who provides care to patients shall maintain and provide to the board upon request one of the following:

a. Evidence that, pursuant to the physician assistant’s employment, there is a physician who is primarily responsible for the overall direction and management of the physician assistant’s professional activities and for assuring that the services
provided by the physician assistant are medically appropriate. In this subd. 1. a., “employment” includes an arrangement between the physician assistant and a 3rd party in which the 3rd party receives payment for services provided by the physician assistant.

b. A written collaborative agreement with a physician that describes the physician assistant’s individual scope of practice and that includes other information as required by the board.

c. If the physician assistant’s practice is limited to the practice of podiatry, a written collaborative agreement with a podiatrist or physician that describes the physician assistant’s individual scope of podiatry practice and that includes other information as required by the board.

2. Subdivision 1. does not require the physical presence of a physician or podiatrist at the time and place a physician assistant renders a service.

3. Subdivision 1. does not apply with respect to a physician assistant who is employed by the federal government as a civilian or member of the uniformed services while performing duties incident to that employment or service.

(b) A physician assistant shall limit his or her practice to the scope of his or her experience, education, and training.

(c) No physician assistant may provide medical care, except routine screening and emergency care, in any of the following:

1. The practice of dentistry or dental hygiene within the meaning of ch. 447.
2. The practice of optometry within the meaning of ch. 449.
3. The practice of chiropractic within the meaning of ch. 446.
(3) (a) It shall be the obligation of a physician assistant to ensure all of the following:

1. That the scope of the practice of a physician assistant is identified and is appropriate with respect to his or her experience, education, and training.

2. For purposes of sub. (2) (a) 1. b. and c., that the relationship with and access to a collaborating physician or podiatrist by the physician assistant is defined.

3. That the requirements and standards of licensure under this chapter are complied with.

4. That consultation with and referral to other licensed health care providers with a scope of practice appropriate for a patient’s care needs occurs when the patient’s care needs exceed the physician assistant’s experience, education, or training. A physician assistant shall ensure that he or she has awareness of options for the management of situations that are beyond the physician assistant’s expertise.

(b) A physician assistant is individually and independently responsible for the quality of the care he or she renders.

(4) A physician assistant may delegate a care task or order to another clinically trained health care worker if the physician assistant is competent to perform the delegated task or order and has reasonable evidence that the clinically trained health care worker is minimally competent to perform the task or issue the order under the circumstances.

(5) The board shall promulgate any rules necessary to implement this section, including rules to do any of the following:

(a) Allow for temporary practice, specifically defined and actively monitored by the board, in the event of an interruption of a collaborative relationship under sub. (2) (a) 1. b. or c.
(b) Allow a physician assistant, in the absence of an employment or collaborative relationship under sub. (2) (a) 1., to provide medical care at the scene of an emergency, during a declared state of emergency or other disaster, or when volunteering at sporting events or at camps.

(6) The practice permissions provided in this section are permissions granted by the state authorizing the licensed practice of physician assistants. Nothing in this section prohibits an employer, hospital, health plan, or other similar entity employing or with a relationship with a licensed physician assistant from establishing additional requirements for a licensed physician assistant as a condition of employment or relationship.

461.11 Civil liability. No physician assistant shall be liable for any civil damages for either of the following:

(1) Reporting in good faith to the department of transportation under s. 146.82 (3) a patient’s name and other information relevant to a physical or mental condition of the patient that in the physician assistant’s judgment impairs the patient’s ability to exercise reasonable and ordinary control over a motor vehicle.

(2) In good faith, not reporting to the department of transportation under s. 146.82 (3) a patient’s name and other information relevant to a physical or mental condition of the patient that in the physician assistant’s judgment does not impair the patient’s ability to exercise reasonable and ordinary control over a motor vehicle.

461.12 Malpractice liability insurance. (1) Except as provided in subs. (2) and (3), no physician assistant may practice as authorized under s. 461.10 unless he or she has in effect malpractice liability insurance coverage evidenced by one of the following:
(a) Personal liability coverage in the amounts specified for health care
providers under s. 655.23 (4).

(b) Coverage under a group liability policy providing individual coverage for the
physician assistant in the amounts under s. 655.23 (4).

(2) The board may promulgate rules requiring a practicing physician assistant
to have in effect malpractice liability insurance coverage in amounts greater than
those specified in sub. (1) (a) or (b) or (4). If the board promulgates rules under this
subsection, no physician assistant may practice as authorized under s. 461.10 unless
he or she has in effect malpractice liability insurance coverage as required under
those rules, except as provided in sub. (3).

(3) A physician assistant who is a state, county, or municipal employee, or
federal employee or contractor covered under the federal tort claims act, as amended,
and who is acting within the scope of his or her employment or contractual duties is
not required to maintain in effect malpractice insurance coverage.

(4) Except as provided in subs. (2) and (3), a physician assistant may comply
with sub. (1) if the physician assistant’s employer has in effect malpractice liability
insurance that is at least the minimum amount specified under s. 655.23 (4) and that
provides coverage for claims against the physician assistant.

461.30 Professional discipline. (1) Subject to the rules promulgated under
s. 440.03 (1), the board may conduct investigations and hearings to determine
whether a person has violated this chapter or a rule promulgated under this chapter.

(2) Subject to the rules promulgated under s. 440.03 (1), if a person who applies
for or holds a license issued under s. 461.07 does any of the following, the board may
reprimand the person or deny, limit, suspend, or revoke the person’s license:
(a) Makes a material misstatement in an application for a license or an
application for renewal of a license under s. 461.07.

(b) Violates any law of this state or federal law that substantially relates to the
practice of a physician assistant, violates this chapter, or violates a rule promulgated
under this chapter.

(c) Advertises, practices, or attempts to practice under another person’s name.

(d) Engages in unprofessional conduct. In this paragraph, “unprofessional
conduct” does not include any of the following:

   1. Providing expedited partner therapy as described in s. 461.035.

   2. Prescribing or delivering an opioid antagonist in accordance with s. 461.037
(2).

(e) Subject to ss. 111.321, 111.322, and 111.335, is arrested for or convicted of
a felony.

(f) Subject to ss. 111.321, 111.322, and 111.34, practices as a physician assistant
while his or her ability is impaired by alcohol or other drugs.

(g) Engages in fraud or deceit in obtaining or using his or her license.

(h) Is adjudicated mentally incompetent by a court.

(i) Demonstrates gross negligence, incompetence, or misconduct in practice.

(j) Knowingly, recklessly, or negligently divulges a privileged communication
or other confidential patient health care information except as required or permitted
by state or federal law.

(k) Fails to cooperate with the board, or fails to timely respond to a request for
information by the board, in connection with an investigation under this section.

(L) Prescribes, sells, administers, distributes, orders, or provides a controlled
substance for a purpose other than a medical purpose.
BILL

(m) Demonstrates a lack of physical or mental ability to safely practice as a physician assistant.

(n) Engages in any practice that is outside the scope of his or her experience, education, or training.

(o) Is disciplined or has been disciplined by another state or jurisdiction based upon acts or conduct similar to acts or conduct prohibited under pars. (a) to (n).

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

(1) Detailed technical information that in all probability a patient would not understand.

(2) Risks apparent or known to the patient.

(3) Extremely remote possibilities that might falsely or detrimentally alarm the patient.

(4) Information in emergencies where failure to provide treatment would be more harmful to the patient than treatment.

(5) Information in cases where the patient is incapable of consenting.
(6) Information about alternate medical modes of treatment for any condition the physician assistant has not included in his or her diagnosis at the time the physician informs the patient.

461.50 Penalties. Any person who violates this chapter is subject to a fine not to exceed $10,000 or imprisonment not to exceed 9 months, or both.

461.51 Injunction. If it appears upon complaint to the board by any person or if it is known to the board that any person is violating this subchapter, or rules adopted by the board under this subchapter, the board or the attorney general may investigate and may, in addition to any other remedies, bring action in the name and on behalf of the state against any such person to enjoin such person from such violation. The attorney general shall represent the board in all proceedings.

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

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

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

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

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

(2) No physician assistant who reports to the board under sub. (1) may be held civilly or criminally liable or be found guilty of unprofessional conduct for reporting in good faith.
SECTION 72. 462.02 (2) (e) of the statutes is amended to read:

462.02 (2) (e) A physician assistant licensed under s. 448.04 (1) (f) 461.07.

SECTION 73. 462.04 of the statutes is amended to read:

462.04 Prescription or order required. A person who holds a license or limited X-ray machine operator permit under this chapter may not use diagnostic X-ray equipment on humans for diagnostic purposes unless authorized to do so by prescription or order of a physician licensed under s. 448.04 (1) (a), a dentist licensed under s. 447.04 (1), a podiatrist licensed under s. 448.63, a chiropractor licensed under s. 446.02, an advanced practice nurse certified under s. 441.16 (2), a physician assistant licensed under s. 448.04 (1) (f) 461.07, or, subject to s. 448.56 (7) (a), a physical therapist licensed under s. 448.53.

SECTION 74. 895.48 (1m) (a) (intro.) of the statutes is amended to read:

895.48 (1m) (a) (intro.) Except as provided in par. (b), any physician, physician assistant, podiatrist, or athletic trainer licensed under ch. 448, chiropractor licensed under ch. 446, dentist licensed under ch. 447, physician assistant licensed under ch. 461, emergency medical services practitioner licensed under s. 256.15, emergency medical responder certified under s. 256.15 (8), registered nurse licensed under ch. 441, or a massage therapist or bodywork therapist licensed under ch. 460 who renders voluntary health care to a participant in an athletic event or contest sponsored by a nonprofit corporation, as defined in s. 66.0129 (6) (b), a private school, as defined in s. 115.001 (3r), a tribal school, as defined in s. 115.001 (15m), a public agency, as defined in s. 46.856 (1) (b), or a school, as defined in s. 609.655 (1) (c), is immune from civil liability for his or her acts or omissions in rendering that care if all of the following conditions exist:

SECTION 75. 961.01 (19) (a) of the statutes is amended to read:
961.01 (19) (a) A physician, advanced practice nurse, dentist, veterinarian, podiatrist, optometrist, scientific investigator or, subject to s. 448.21 (3), a physician assistant, or other person licensed, registered, certified or otherwise permitted to distribute, dispense, conduct research with respect to, administer, or use in teaching or chemical analysis a controlled substance in the course of professional practice or research in this state.

**SECTION 76.** 971.14 (4) (a) of the statutes is amended to read:

971.14 (4) (a) The court shall cause copies of the report to be delivered forthwith to the district attorney and the defense counsel, or the defendant personally if not represented by counsel. Upon the request of the sheriff or jailer charged with care and control of the jail in which the defendant is being held pending or during a trial or sentencing proceeding, the court shall cause a copy of the report to be delivered to the sheriff or jailer. The sheriff or jailer may provide a copy of the report to the person who is responsible for maintaining medical records for inmates of the jail, or to a nurse licensed under ch. 441, **a** physician assistant licensed under ch. 461, or to a physician assistant licensed under subch. II of ch. 448 who is a health care provider for the defendant or who is responsible for providing health care services to inmates of the jail. The report shall not be otherwise disclosed prior to the hearing under this subsection.

**SECTION 77.** 990.01 (27s) of the statutes is created to read:

990.01 (27s) **Physician assistant** or “physician associate” means a person licensed as a physician assistant under ch. 461.

**SECTION 78.** Chapter Med 8 of the administrative code is repealed.

**SECTION 79.** Nonstatutory provisions.
(1) **Board; Appointments.**

(a) Notwithstanding the length of terms specified for the members of the physician assistant examining board under s. 15.405 (4), 3 of the initial members under s. 15.405 (4) (a) 1. and the initial member under s. 15.405 (4) (a) 2. shall be appointed for terms expiring on July 1, 2021; 3 of the initial members under s. 15.405 (4) (a) 1. and the initial member under s. 15.405 (4) (a) 3. shall be appointed for terms expiring on July 1, 2022; and the remaining initial member under s. 15.405 (4) (a) 1. shall be appointed for a term expiring on July 1, 2023.

(b) Notwithstanding s. 15.08 (1), the governor may provisionally appoint initial members of the physician assistant examining board under s. 15.405 (4). Those provisional appointments remain in force until withdrawn by the governor or acted upon by the senate and if confirmed by the senate, shall continue for the remainder of the unexpired term, if any, of the member and until a successor is chosen and qualifies. A provisional appointee may exercise all the powers and duties of board membership to which the person is appointed during the time in which the appointee qualifies.

(c) Notwithstanding s. 15.405 (4) (a) 1. and 2., for purposes of an initial appointment to the physician assistant examining board made before the date specified in **SECTION 80** (intro.) of this act, including any provisional appointment made under par. (b), the governor may appoint physician assistants licensed under subch. II of ch. 448 to the positions on the board specified under s. 15.405 (4) (a) 1. and 2.

(2) **Emergency rules.**

(a) Using the procedure under s. 227.24, the physician assistant examining board may promulgate initial rules under ss. 461.05 (1) and 461.10 (5) as emergency
rules under s. 227.24 to allow for the licensure, discipline, and practice of physician
assistants. The authority granted under this subsection applies only to rules
described in this paragraph, and any other emergency rules promulgated by the
board shall be as provided in, and subject to, s. 227.24.

(b) Notwithstanding s. 227.24 (1) (a) and (3), the physician assistant examining
board is not required to provide evidence that promulgating a rule under this
subsection as an emergency rule is necessary for the preservation of the public peace,
health, safety, or welfare and is not required to provide a finding of emergency for a
rule promulgated under this subsection.

(c) Emergency rules promulgated under this subsection may not take effect
prior to the date specified in Section 80 (intro.) of this act.

(d) Notwithstanding s. 227.24 (1) (c), emergency rules promulgated under this
subsection remain in effect for one year, subject to extension under par. (e), or until
the date on which permanent rules take effect, whichever is sooner.

(e) Notwithstanding s. 227.24 (2) (a), the joint committee for review of
administrative rules may, at any time prior to the expiration date of the emergency
rule promulgated under this subsection, extend the effective period of the emergency
rule at the request of the physician assistant examining board for a period specified
by the committee not to exceed 180 days. Any number of extensions may be granted
under this paragraph, but the total period for all extensions may not extend beyond
the expiration date of the emergency rule’s statement of scope under s. 227.135 (5).
Notwithstanding s. 227.24 (2) (b) 1., the physician assistant examining board is not
required to provide evidence that there is a threat to the public peace, health, safety,
or welfare that can be avoided only by extension of the emergency rule when making
a request for an extension under this subsection, but s. 227.24 (2) (am) to (c) shall otherwise apply to extensions under this paragraph.

(f) If the physician assistant examining board promulgates emergency rules under this subsection, the board shall submit a single statement of scope for both permanent emergency rules.

(3) Board; transfers.

(a) Tangible personal property. On the effective date of this paragraph, all tangible personal property, including records, of the medical examining board that the secretary of safety and professional services determines to be primarily related to the regulation of physician assistants is transferred to the physician assistant examining board.

(b) Pending matters. Any matter pending with the medical examining board on the effective date of this paragraph that is primarily related to the regulation of physician assistants, as determined by the secretary of safety and professional services, is transferred to the physician assistant examining board. All materials submitted to or actions taken by the medical examining board with respect to the pending matter are considered as having been submitted to or taken by the physician assistant examining board.

(c) Contracts. All contracts entered into by the medical examining board in effect on the effective date of this paragraph that are primarily related to the regulation of physician assistants, as determined by the secretary of safety and professional services, remain in effect and are transferred to the physician assistant examining board. The physician assistant examining board shall carry out any obligations under such a contract until the contract is modified or rescinded by the physician assistant examining board to the extent allowed under the contract.
(d) Assets and liabilities. On the effective date of this paragraph, the assets and liabilities of the medical examining board that are primarily related to the regulation of physician assistants, as determined by the secretary of safety and professional services, become the assets and liabilities of the physician assistant examining board.

(e) Orders. All orders issued by the medical examining board in effect on the effective date of this paragraph that are primarily related to the regulation of physician assistants remain in effect until their specified expiration dates or until modified or rescinded by the physician assistant examining board.

SECTION 80. Effective dates. This act takes effect on the first day of the 13th month beginning after publication, except as follows:

(1) The treatment of s. 15.405 (4) and SECTION 79 (1) and (2) of this act take effect on the day after publication.

(2) Notwithstanding s. 227.265, the treatment of ch. Med 8 of the administrative code takes effect on the first day of the 13th month beginning after publication.

(END)
# AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request:  
Valerie Payne, Executive Director, on behalf of Dr. Bruce Wasserman

2) Date When Request Submitted:  
11/12/19

Items will be considered late if submitted after 4:30 p.m. and less than:  
- 10 work days before the meeting for Medical Board  
- 14 work days before the meeting for all others

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

4) Meeting Date:  
11/20/19

5) Attachments:  
- Yes  
- No

6) How should the item be titled on the agenda page?  
I. Legislative and Policy Matters – Discussion and Consideration  
Permitting Pharmacists to Prescribe Certain Contraceptives

7) Place Item in:  
- Open Session  
- Closed Session  
- Both

8) Is an appearance before the Board being scheduled?  
- Yes (Fill out Board Appearance Request)  
- No

9) Name of Case Advisor(s), if required:  

10) Describe the issue and action that should be addressed:  
Discuss proposed bill, AB304/LRB-0325-1, relating to: permitting pharmacists to prescribe certain contraceptives, extending the time limit for emergency rule procedures, providing an exemption from emergency rule procedures, granting rule-making authority, and providing a penalty.

The bill requires the Pharmacy Examining Board, after consultation with the Medical Examining Board, the Board of Nursing, and the Department of Health Services, to promulgate rules to establish standard procedures for the prescribing of contraceptives by pharmacists under the bill.

11) Authorization  
Valerie Payne  
11/12/19

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.
2019 ASSEMBLY BILL 304

June 20, 2019 – Introduced by Representatives KITCHENS, FELZKOWSKI, AUGUST, BORN, DITTRICH, DUCHOW, JAMES, KERKMAN, KNOKL, KRUG, KUGLITSCH, KURTZ, LOUDENBECK, MACCO, MAGNAFICI, MURSAU, NEYLON, NOVAK, NYGREN, OLDBURG, PLUMER, RAMTHUN, ROHRKASTE, SKOWRONSKI, SNYDER, SPIROS, STEFFEN, STEINEKE, SUMMERFIELD, SWARINGEN, TITTL, TRANEL, TUSLER, VORPAGEL, VOS and WITTKE, cosponsored by Senators BERNIER, DARLING, FEYEN, MARKLEIN, TESTIN and WANGGAARD. Referred to Committee on Health.

AN ACT to amend 450.095 (title) and 450.095 (3); and to create 450.01 (16) (L), 450.095 (1) (ag) and (ar) and 450.095 (2m) of the statutes; relating to: permitting pharmacists to prescribe certain contraceptives, extending the time limit for emergency rule procedures, providing an exemption from emergency rule procedures, granting rule-making authority, and providing a penalty.

Analysis by the Legislative Reference Bureau
This bill permits a pharmacist to prescribe and dispense hormonal contraceptive patches and self-administered oral hormonal contraceptives, subject to limitations described as follows.

The bill requires the Pharmacy Examining Board, after consultation with the Medical Examining Board, the Board of Nursing, and the Department of Health Services, to promulgate rules to establish standard procedures for the prescribing of contraceptives by pharmacists under the bill. The rules must include a self-assessment questionnaire, developed in consideration of guidelines established by the American Congress of Obstetricians and Gynecologists, that must be used by a pharmacist when prescribing a contraceptive. The rules must include certain requirements for pharmacists prescribing contraceptives, such as 1) requiring a report to the patient’s primary health care practitioner following a prescription, and 2) requiring the contraceptive to be dispensed as soon as practicable after the pharmacist issues the prescription order. In addition, the rules must prohibit a pharmacist from prescribing or dispensing a contraceptive to a patient unless 1) the
patient has responded to the self-assessment questionnaire and undergone a blood pressure screening and 2) the use of the contraceptive is not contraindicated based upon the results of the questionnaire and screening. A pharmacist who prescribes contraceptives as permitted under the bill must comply with those rules, as well as any other rules promulgated by the Pharmacy Examining Board. Finally, under the bill, a pharmacist may prescribe a contraceptive only to a person who is at least 18 years of age.

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

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

**SECTION 1.** 450.01 (16) (L) of the statutes is created to read:

450.01 (16) (L) Prescribing and dispensing hormonal contraceptive patches and self-administered oral hormonal contraceptives pursuant to s. 450.095 (2m).

**SECTION 2.** 450.095 (title) of the statutes is amended to read:

450.095 (title) **Duty to dispense Prescribing and dispensing of contraceptives.**

**SECTION 3.** 450.095 (1) (ag) and (ar) of the statutes are created to read:

450.095 (1) (ag) “Hormonal contraceptive patch” means a transdermal patch applied to the skin of a patient, by the patient or by a practitioner, that releases a drug composed of a combination of hormones that is approved by the federal food and drug administration to prevent pregnancy.

(ar) “Self-administered oral hormonal contraceptive” means a drug composed of a combination of hormones that is approved by the federal food and drug administration to prevent pregnancy and that the patient to whom the drug is prescribed may take orally.

**SECTION 4.** 450.095 (2m) of the statutes is created to read:
450.095 (2m) (a) In accordance with rules promulgated by the board, a pharmacist may prescribe and dispense hormonal contraceptive patches and self-administered oral hormonal contraceptives to a person who is at least 18 years of age.

(b) 1. The board shall, after consultation with the medical examining board, the board of nursing, and the department of health services, promulgate rules to establish standard procedures for the prescribing of hormonal contraceptive patches and self-administered oral hormonal contraceptives by pharmacists under this subsection.

2. The rules promulgated under subd. 1. shall include a self-assessment questionnaire, developed in consideration of guidelines established by the American Congress of Obstetricians and Gynecologists, that must be used by a pharmacist as described in subd. 3. a.

3. The rules promulgated under subd. 1. shall require a pharmacist to do all of the following:

   a. Provide the self-assessment questionnaire described in subd. 2. to a patient prior to the pharmacist’s prescribing the hormonal contraceptive patch or self-administered oral hormonal contraceptive to the patient.

   b. Report to the patient’s primary care practitioner upon prescribing and dispensing the hormonal contraceptive patch or self-administered oral hormonal contraceptive.

   c. Provide the patient with a written record of the hormonal contraceptive patch or self-administered oral hormonal contraceptive prescribed and dispensed.
d. Dispense the hormonal contraceptive patch or self-administered oral hormonal contraceptive to the patient as soon as practicable after the pharmacist issues the prescription order.

4. The rules promulgated under subd. 1. shall prohibit a pharmacist from prescribing and dispensing a hormonal contraceptive patch or self-administered oral hormonal contraceptive to a patient unless all of the following apply:
   a. The patient has responded to the self-assessment questionnaire provided under subd. 3. a. and undergone a blood pressure screening.
   b. The use of the hormonal contraceptive patch or self-administered oral hormonal contraceptive by the patient is not contraindicated based upon the results of the questionnaire and screening.

SECTION 5. 450.095 (3) of the statutes is amended to read:

450.095 (3) Any person who violates this section or any rules promulgated under this section may be required to forfeit not less than $250 nor more than $2,500 for each violation.


(1) The pharmacy examining board may promulgate emergency rules under s. 227.24 necessary to implement this act. Notwithstanding s. 227.24 (1) (c) and (2), emergency rules promulgated under this subsection remain in effect until May 1, 2021, or the date on which permanent rules take effect, whichever is sooner. Notwithstanding s. 227.24 (1) (a) and (3), the examining board is not required to provide evidence that promulgating a rule under this subsection as an emergency rule is necessary for the preservation of the public peace, health, safety, or welfare and is not required to provide a finding of emergency for a rule promulgated under this subsection.
SECTION 7. Effective dates. This act takes effect on the first day of the 10th month beginning after publication, except as follows:

(1) SECTION 6 (1) of this act takes effect on the day after publication.
# State of Wisconsin
## Department of Safety & Professional Services

### AGENDA REQUEST FORM

<table>
<thead>
<tr>
<th>1) Name and Title of Person Submitting the Request:</th>
<th>2) Date When Request Submitted:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valerie Payne, Executive Director, on behalf of Dr. Kenneth Simons</td>
<td>11/12/19</td>
</tr>
</tbody>
</table>

Items will be considered late if submitted after 4:30 p.m. and less than:
- 10 work days before the meeting for Medical Board
- 14 work days before the meeting for all others

<table>
<thead>
<tr>
<th>3) Name of Board, Committee, Council, Sections:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Examining Board</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4) Meeting Date:</th>
<th>5) Attachments:</th>
<th>6) How should the item be titled on the agenda page?</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/20/19</td>
<td>☑ Yes</td>
<td>I. Legislative and Policy Matters – Discussion and Consideration</td>
</tr>
<tr>
<td></td>
<td>☐ No</td>
<td>LRB-4287-1 Continuing Education on Suicide Prevention</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7) Place Item in:</th>
<th>8) Is an appearance before the Board being scheduled?</th>
<th>9) Name of Case Advisor(s), if required:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Open Session</td>
<td>☑ Yes (Fill out Board Appearance Request)</td>
<td></td>
</tr>
<tr>
<td>☐ Closed Session</td>
<td>☐ No</td>
<td></td>
</tr>
<tr>
<td>☐ Both</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10) Describe the issue and action that should be addressed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss proposed bill, AB526/LRB-4287-1, relating to: requiring continuing education on suicide prevention for physicians, psychologists, social workers, marriage and family therapists, professional counselors, and substance abuse counselors and requiring the exercise of rule-making authority.</td>
</tr>
</tbody>
</table>

This bill requires two hours of continuing education on suicide prevention to be completed every two years for each of the following types of practitioners to renew their credentials: 1) physicians; 2) psychologists; 3) private practice school psychologists; 4) social workers; 5) advanced practice social workers; 6) independent social workers; 7) clinical social workers; 8) marriage and family therapists; 9) professional counselors; 10) substance abuse counselors; 11) clinical substance abuse counselors; and 12) prevention specialists. Under current law, each of those types of professionals must complete at least 30 hours of continuing education every two years to renew their credentials, except that psychologists and private practice school psychologists are required to complete 40 hours of continuing education every two years to renew their licenses.

<table>
<thead>
<tr>
<th>11) Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valerie Payne 11/12/19</td>
</tr>
</tbody>
</table>

Signature of person making this request Date

<table>
<thead>
<tr>
<th>Supervisor (if required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
</tr>
</tbody>
</table>

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.
October 14, 2019 - Introduced by Representatives KURTZ, BALLWEG, DOYLE, CABRERA, DUCHOW, EDMING, JAMES, MILROY, MURSAU, OLDENBURG, PETERSEN, PETRYK, RAMTHUN, RODRIGUEZ, ROHRKASTE, SCHRAA, SPIROS, C. TAYLOR, TITTL, TRANEL, TUSLER, VANDERMEER, VINING and WITTK, co-sponsored by Senators BERNIER, CARPENTER, NASS, OLSEN and L. TAYLOR. Referred to Committee on Health.

AN ACT to consolidate, renumber and amend 440.88 (9) (intro.) and (b); to amend 440.88 (9) (a), 448.13 (1) (a) 1., 455.065 (1) and 457.22 (1) (intro.); and to create 457.22 (3) of the statutes; relating to: requiring continuing education on suicide prevention for physicians, psychologists, social workers, marriage and family therapists, professional counselors, and substance abuse counselors and requiring the exercise of rule-making authority.

Analysis by the Legislative Reference Bureau

This bill requires two hours of continuing education on suicide prevention to be completed every two years for each of the following types of practitioners to renew their credentials: 1) physicians; 2) psychologists; 3) private practice school psychologists; 4) social workers; 5) advanced practice social workers; 6) independent social workers; 7) clinical social workers; 8) marriage and family therapists; 9) professional counselors; 10) substance abuse counselors; 11) clinical substance abuse counselors; and 12) prevention specialists. Under current law, each of those types of professionals must complete at least 30 hours of continuing education every two years to renew their credentials, except that psychologists and private practice school psychologists are required to complete 40 hours of continuing education every two years to renew their licenses.
For further information see the state fiscal estimate, which will be printed as an appendix to this bill.

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

SECTION 1. 440.88 (9) (intro.) and (b) of the statutes are consolidated, renumbered 440.88 (9) (bm) and amended to read:

440.88 (9) (bm) The department may do all of the following: (b) Require continuing education as part of any disciplinary process for an individual.

SECTION 2. 440.88 (9) (a) of the statutes is amended to read:

440.88 (9) (a) Establish The department shall establish the minimum number of hours of continuing education required for renewal of certification under this section and the topic areas that the continuing education must cover. The rules promulgated under this paragraph shall require each substance abuse counselor, clinical substance abuse counselor, and prevention specialist to complete at least 2 hours of continuing education programs or courses on suicide prevention to renew a certification under this section.

SECTION 3. 448.13 (1) (a) 1. of the statutes is amended to read:

448.13 (1) (a) 1. Continuing education programs or courses of study approved for at least 30 hours of credit by the board within the 2 calendar years preceding the calendar year for which the registration is effective. The board shall promulgate rules requiring a physician to complete at least 2 credit hours of continuing education programs or courses approved by the board on suicide prevention.

SECTION 4. 455.065 (1) of the statutes is amended to read:

455.065 (1) Promulgate rules establishing the minimum number of hours of continuing education, the topic areas that the continuing education must cover, the
criteria for the approval of continuing education programs and courses required for
renewal of a license and the criteria for the approval of the sponsors and cosponsors
of those continuing education programs and courses. The rules promulgated under
this subsection shall require each person licensed under s. 455.04 (1) or (4) to
complete at least 2 hours of continuing education programs or courses on suicide
prevention to renew the person’s license. The rules promulgated under this
subsection may not count continuing education programs or courses on suicide
prevention more than continuing education programs or courses on any other topic.

SECTION 5. 457.22 (1) (intro.) of the statutes is amended to read:

457.22 (1) (intro.) The examining board may shall do any all of the following:

SECTION 6. 457.22 (3) of the statutes is created to read:

457.22 (3) The rules promulgated under sub. (1) shall require social workers,
advanced practice social workers, independent social workers, clinical social
workers, marriage and family therapists, and professional counselors to complete at
least 2 hours of continuing education programs or courses of study on suicide
prevention in order to qualify for renewal.
**State of Wisconsin**  
**Department of Safety & Professional Services**

### AGENDA REQUEST FORM

<table>
<thead>
<tr>
<th>1) Name and Title of Person Submitting the Request:</th>
<th>2) Date When Request Submitted:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valerie Payne, Executive Director, on behalf of Dr. Kenneth Simons</td>
<td>11/12/19</td>
</tr>
</tbody>
</table>

*Items will be considered late if submitted after 4:30 p.m. and less than:*  
- 10 work days before the meeting for Medical Board  
- 14 work days before the meeting for all others

<table>
<thead>
<tr>
<th>3) Name of Board, Committee, Council, Sections:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Examining Board</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4) Meeting Date:</th>
<th>5) Attachments:</th>
<th>6) How should the item be titled on the agenda page?</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/20/19</td>
<td>Yes</td>
<td>Proposed Neonatal Abstinence Syndrome Opioid Guidelines for MEB To Develop</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7) Place Item in:</th>
<th>8) Is an appearance before the Board being scheduled?</th>
<th>9) Name of Case Advisor(s), if required:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Session</td>
<td>No (Fill out Board Appearance Request)</td>
<td></td>
</tr>
<tr>
<td>Closed Session</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Discussion of proposed bill, LRB-4530/1 relating to guidelines regarding the treatment of neonatal abstinence syndrome.

This bill requires the Medical Examining Board to issue guidelines regarding best practices for the treatment of neonatal abstinence syndrome, a condition that may occur in a newborn following the discontinuation of fetal exposure to substances that were used by the mother during pregnancy.

---

11) **Authorization**

<table>
<thead>
<tr>
<th>Valerie Payne</th>
<th>11/12/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of person making this request</td>
<td>Date</td>
</tr>
<tr>
<td>Supervisor (if required)</td>
<td>Date</td>
</tr>
</tbody>
</table>

**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.
AN ACT to consolidate, renumber and amend 440.88 (9) (intro.) and (b); to amend 440.88 (9) (a), 448.13 (1) (a) 1., 455.065 (1) and 457.22 (1) (intro.); and to create 457.22 (3) of the statutes; relating to: requiring continuing education on suicide prevention for physicians, psychologists, social workers, marriage and family therapists, professional counselors, and substance abuse counselors and requiring the exercise of rule-making authority.

Analysis by the Legislative Reference Bureau

This bill requires two hours of continuing education on suicide prevention to be completed every two years for each of the following types of practitioners to renew their credentials: 1) physicians; 2) psychologists; 3) private practice school psychologists; 4) social workers; 5) advanced practice social workers; 6) independent social workers; 7) clinical social workers; 8) marriage and family therapists; 9) professional counselors; 10) substance abuse counselors; 11) clinical substance abuse counselors; and 12) prevention specialists. Under current law, each of those types of professionals must complete at least 30 hours of continuing education every two years to renew their credentials, except that psychologists and private practice school psychologists are required to complete 40 hours of continuing education every two years to renew their licenses.
SENATE BILL 520

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

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

SECTION 1. 440.88 (9) (intro.) and (b) of the statutes are consolidated, renumbered 440.88 (9) (bm) and amended to read:

440.88 (9) (bm) The department may do all of the following: (b) Require continuing education as part of any disciplinary process for an individual.

SECTION 2. 440.88 (9) (a) of the statutes is amended to read:

440.88 (9) (a) Establish The department shall establish the minimum number of hours of continuing education required for renewal of certification under this section and the topic areas that the continuing education must cover. The rules promulgated under this paragraph shall require each substance abuse counselor, clinical substance abuse counselor, and prevention specialist to complete at least 2 hours of continuing education programs or courses on suicide prevention to renew a certification under this section.

SECTION 3. 448.13 (1) (a) 1. of the statutes is amended to read:

448.13 (1) (a) 1. Continuing education programs or courses of study approved for at least 30 hours of credit by the board within the 2 calendar years preceding the calendar year for which the registration is effective. The board shall promulgate rules requiring a physician to complete at least 2 credit hours of continuing education programs or courses approved by the board on suicide prevention.

SECTION 4. 455.065 (1) of the statutes is amended to read:

455.065 (1) Promulgate rules establishing the minimum number of hours of continuing education, the topic areas that the continuing education must cover, the
criteria for the approval of continuing education programs and courses required for renewal of a license and the criteria for the approval of the sponsors and cosponsors of those continuing education programs and courses. The rules promulgated under this subsection shall require each person licensed under s. 455.04 (1) or (4) to complete at least 2 hours of continuing education programs or courses on suicide prevention to renew the person’s license. The rules promulgated under this subsection may not count continuing education programs or courses on suicide prevention more than continuing education programs or courses on any other topic.

SECTION 5. 457.22 (1) (intro.) of the statutes is amended to read:

457.22 (1) (intro.) The examining board may shall do any all of the following:

SECTION 6. 457.22 (3) of the statutes is created to read:

457.22 (3) The rules promulgated under sub. (1) shall require social workers, advanced practice social workers, independent social workers, clinical social workers, marriage and family therapists, and professional counselors to complete at least 2 hours of continuing education programs or courses of study on suicide prevention in order to qualify for renewal.
**State of Wisconsin**  
**Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

<table>
<thead>
<tr>
<th>1) Name and title of person submitting the request:</th>
<th>2) Date when request submitted:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valerie Payne, Executive Director, on behalf of Kenneth Simons</td>
<td>12/11/19</td>
</tr>
</tbody>
</table>

Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting.

<table>
<thead>
<tr>
<th>3) Name of Board, Committee, Council, Sections:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Examining Board</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4) Meeting Date:</th>
<th>5) Attachments:</th>
<th>6) How should the item be titled on the agenda page?</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/18/19</td>
<td>☑ Yes</td>
<td>Interstate Medical Licensure Compact (IMLCC)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7) Place Item in:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Open Session</td>
</tr>
<tr>
<td>□ Closed Session</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8) Is an appearance before the Board being scheduled? (If yes, please complete Appearance Request for Non-DSPS Staff)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9) Name of Case Advisor(s), if required:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10) Describe the issue and action that should be addressed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interstate Medical Licensure Compact report out on attendance and participation at the annual meeting held on November 19, 2019. Attachment details the newly elected officers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11) Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valerie Payne</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of person making this request</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supervisor (if required)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Executive Director signature (indicates approval to add post agenda deadline item to agenda)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.
November 26, 2019

For Immediate Release

The Commissioners of the Interstate Medical Licensure Compact Commission (IMLCC) held their annual meeting on Tuesday, November 19, 2019. Part of the meeting included the election of officers for the IMLCC, the newly elected officers assumed their positions at the conclusion of the meeting.

- Commissioner Timothy Terranova from Maine was elected Chair
- Commissioner Edward Cousineau from Nevada was elected Vice Chair
- Commissioner Christine Farrelly from Maryland was elected Treasurer
- Commissioner Kenneth Simons from Wisconsin is now filling the role of Past Chair.

Committee membership and the Committee Chairs are being assigned in accordance with the IMLCC Bylaws. Regular meeting of the committees will resume in December and January. The newly formed Executive Committee is scheduled for Tuesday, December 3, 2019. Information about the meeting can be found under the “Commission” Tab of the IMLCC’s webpage – imlcc.org

For more information contact Marschall Smith, Executive Director at imlccexecutivedirector@imlcc.net