RESOLUTION

"RESOLVED, that the rules relating to continuing medical education and physician emeritus status identified as 7 MCAR §§ 4.012-4.013 are found to be reasonable, necessary and supported by the evidence contained in the record, and are hereby approved and adopted, pursuant to authority vested in us by Minn. Stat. §§ 147.01, subd. 3 (1982) and 214.12 (1982) and that Arthur W. Poore, Executive Secretary of the Minnesota Board of Medical Examiners, be and hereby is authorized to sign an order adopting those rules."

Passed on 3/10/84

CONTINUING MEDICAL EDUCATION RULES

STATEMENT OF NEED AND REASONABLENESS

DRAFT 4

Minn. Stat. §§ 214.12 (1976) permits the Board of Medical Examiners to set by rule, continuing medical education (CME) requirements for all physicians licensed by the State of Minnesota. The Accreditation Council on Continuing Medical Education has developed the following definition of CME, "Continuing Medical Education consists of educational activities which serve to maintain, develop, or increase the knowledge, skills and professional performance and relationships that a physician uses to provide services for patients, the public or the profession. The content of CME is that body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline or clinical medicine, and the provision of health care to the public."

This broad definition of CME as developed by the ACCME recognizes that all continuing education activities which assist physicians in carrying out their professional responsibilities more effectively and efficiently are CME. A course in management would be appropriate CME for physicians responsible for mangaging a health care facility; a course in methodology would be appropriate CME for physicians teaching in a medical school; a course in practice management would be appropriate for practitioners interested in providing better services to patients.

Not all continuing educational activities which physicians may engage in, however, are CME. Physicians may participate in worthwhile continuing educational activities which are not related directly to their professional work, and these activities are not CME. Continuing educational activities which respond to a physician's non professional educational need or interest, such as personal financial planning, and appreciation of literature or music, are not CME.

Rules were drafted for the purpose of implementing this statute in 1977, however in implementing this rule the Board has come across various changes which could be made to the rules, but would still comply with the intent of the statutes. Specifically, the implementation of the original rules and a review of the literature regarding CME, has shown that the most effective CME activities are those with an organized structure which allows for an indentification of the audience's needs, clear goals and objectives, relevant learning methods, and a systematic effort to evaluate. It appeared that by concentrating the CME requirements into those activities with a structured format, or what is called category 1 in the rules, the overall requirement could be reduced while still maintaining an acceptable level of capacity for competence, the reasons will be further explained in this document. The rule change is for the purpose of reducing the required number of hours and to make additional alterations in the rules necessitated by the rule change. In considering the requirements imposed by these rules the Board of Medical Examiners was particularly concerned with the following points:

1. To protect the health and welfare of the citizens of Minnesota by insuring that the physicians practicing in this state not only are qualified for licensure but that they continue to maintain their competency by continuing their education.

2. To insure that continuing medical education courses are of satisfactory quality and flexibility to provide beneficial learning opportunities.

3. To avoid drafting rules which may be counterproductive by making requirements so restrictive that many physicians, particularly those participating in more isolated rural areas, are unable to meet them; or to avoid drafting rules which require excessive hours of continuing medical education beyond what would be necessary to retain a physician's medical skills.

7 MCAR 4.012 Continuing Medical Education

A. "150" (HOURS OF CONTINUING MEDICAL EDUCATION) HAS BEEN DELETED FROM THE RULES AND "75" (HOURS OF CONTINUING MEDICAL EDUCATION) HAS BEEN ADDED IN ITS PLACE. When the Continuing Medical Education rules were first promulgated the concept was new and there was little empirical data in regards to establishing a required number of hours. In that the Board had no way of establishing a balance between enhancing physician capacity for competence and protecting against unduly restrictive requirements, requirements were established by the existing requirements established by various professional associations. The requirement of 150 hours was established by the American Accademy of Family Practice, the American Medical Association, the American Osteopathic Association, and the American Board of Family Practice, and was therefore adopted by the Board. However, it should be pointed out that professional association requirements are usually for a voluntary certificate of achievement or recognition which is not the same as the Board's intention of establishing a minimum level of capacity of competence as a means of protecting the public. The Board does not feel that the requirement of 150 hours of Continuing Medical Education has been unduly harsh or restrictive, however it does appear to be more than what would be needed to insure a minimum level of continued capacity for competence, particularly with a concentration on structurally organized CME activities, which will be a chief concern of this rule revision. Since the promulgation of the Minnesota CME requirement other states have have implemented continuing medical education requirements. In a survey of state medical boards made in 1982 of the nineteen states responding and having CME requirements, eight states had requirements equivalent to between 20 - 30 hours per year with the bulk of the hours concentrating in category one. Category one as defined by the Minnesota Board of Medical Examiners includes activities planned either by (a) organizations most familiar with the needs of physicians (e.g.,

medical schools and medical societies) or (b) organizations accredited as providers of CME. This resetting of the CME requirements at 75 hours for the three year reporting period would be in line with other states. The board feels that the three year reporting cycle should be retained in that it does provide flexibility so that physicians need not be concerned about an immediate "deadline" in which to meet the requirements and the physician would have the capacity to compensate should he or she be unable to attend CME activities for a period of time.

1. *"THE BOARD WILL ESTABLISH THREE CLASSES OF LICENSEES AS FOLLOWS:" HAS BEEN DELETED FROM THE RULES AND "EACH INDIVIDUAL INITIALLY LICENSED AFTER THE EFFECTIVE DATE OF THIS RULE COMMENCES HIS OR HER FIRST-THREE-YEAR CYCLE ON JANUARY 1 FOLLOWING THE DATE OF INITIAL LICENSURE. FUTURE CYCLES WILL RUN CONSECUTIVELY FROM THAT POINT. CONTINUING MEDICAL EDUCATION TAKEN BETWEEN THE DATE OF INITIAL LICENSURE MAY BE CREDITED TOWARDS THE FIRST CYCLE," HAS BEEN ADDED IN ITS PLACE. ALSO THIS ITEM HAS BEEN COMBINED WITH SUB-SECTION A AND SUB ITEMS a,b, AND c UNDER ITEM 1 HAVE ALL BEEN DELETED.*

   When the Continuing Medical Education requirements were first implemented the rules were set up to place physicians licensed before the promulgation of the original rules into three separate groups. Each group would report their CME's every three years in staggered succession, so as to spread out the workload over each annual renewal. However, this system of assigning CME reporting cycles applies only to physicians licensed before the promulgation of the original rules, and since these physicians have all been assigned a reporting cycle under the old rules, this section of the old rules no longer serves a purpose and it is reasonable that it be omitted.

The statement added on to this item defines how physicians licensed after the promulgation of these rules will be assigned reporting cycles. Since the method of assigning reporting cycles is the same as the method of assigning reporting cycles under the old rules for physicians licensed after the promulgation of the old rules, this part of the rules should require little explanation. It has been moved from sub-section three to sub-section one in it is now the sole method of assigning a CME reporting cycle class for newly licensed physicians.

It is reasonable that all succeeding reporting cycles will run consecutively from the first cycle. Besides being logical, it will prevent physicians from trying to circumvent the CME requirements by rearranging their reporting cycles and will prevent needless record work by the Board necessitated by the CME reporting cycle changes.

The time period between the physician's initial licensure and the January 1, following the date of initial licensure may be used for taking CME activities for the first reporting cycle. It is reasonable the initial licensee be given this extra amount of time to their first CME reporting cycle, the extra time may function as a time to learn where CME activities may be taken. Also it is important that the CME reporting cycles coincide with the renewal periods or else it would mean added workload to the Board staff and confusion among licensed physicians in dealing with non-concurring licensure and CME reporting periods. The other alternative is to count the time period between the physician's initial licensure as the first year of the three year CME reporting period. To do this would give December licensees barely two years to make up three years of CME credit. By adding

the time period before the first January 1 following initial licensure to the CME reporting period would mean that the longest CME reporting period would be 3 years and eleven months which would not represent a threat to the public's health and protection. This would be especially true in that most initial licensees would have just completed medical school and a residency.

Items a, b, and c establish the reporting cycle classes for those physicians licensed prior to promulgation of the initial CME reproting cycle. Since these physicians have been assigned CME reporting cycles, and have all complied with the initial CME report, these three items no longer serve a function. Therefore, it is reasonable that they be omitted.

2. *"THE BOARD SHALL PLACE LICENSEES IN THESE THREE CLASSES SO AS TO CREATE CLASSES THAT ARE APPROXIMATELY EQUAL. NO OTHER STANDARD SHALL BE USED IN DETERMINING THE CLASS INTO WHICH LICENSEES SHALL BE PLACED," HAS BEEN DELETED AND "THOSE INDIVIDUALS ASSIGNED THREE YEAR REPORTING PERIODS PRIOR TO THE EFFECTIVE DATE OF THIS RULE SHALL REMAIN IN THEIR ASSIGNED REPORTING CYCLE" HAS BEEN ADDED IN ITS PLACE. ALSO THIS ITEM HAS BEEN COMBINED WITH SUB-SECTION A.*

Under the old rules, physicians licensed before the promulgation of the old CME rules were placed in three CME cycle classes of relative equality of the class sizes and has been insured, by the fact that the number of newly licensed physicians for each year should be relatively equal, it is reasonable that this section be dropped from the rules.

Since the three CME reporting cycle classes have been established into three relatively equal groups consisting of all physicians currently licensed to practice medicine in Minnesota,

as was the intent of the original rule, it would serve no purpose to assign the physicians licensed prior to the promulgation of the revised rules into new CME reporting cycle classes. Therefore, it is reasonable that those physicians licensed prior to the promulgation of the new rules shall retain the CME reporting cycle assigned under the original rule.

3. "EACH PERSON INITIALLY LICENSED AFTER THE EFFECTIVE DATE OF THIS RULE SHALL COMMENCE HIS OR HER FIRST THREE YEAR CYCLE ON JANUARY 1, FOLLOWING THE DATE OF INITIAL LICENSURE" HAS BEEN DELETED.

This item refers to the standard used to determine the CME reporting cycle classes for those physicians licensed after the promulgation of the rules. Since this standard is now the sole standard for determining CME reporting cycles and has already been stated in item A.1., it is reasonable that this item be dropped in order to avoid redundancy.

B. SUBSECTION B. ESTABLISHES THE VARIOUS CATEGORIES IN WHICH PHYSICIANS MAY OBTAIN CONTINUING MEDICAL EDUCATION CREDITS. WHILE SUBSECTION B REMAINS THE SAME, IN THE FIVE ITEMS UNDER B, THE NUMBER OF HOURS WHICH MAY BE TAKEN UNDER EACH CATEGORY HAS BEEN CHANGED.

The chief concern of the rules was "category one" training. This training was designed to include those CME activities most likely to be effective. "Category one" training included classes, seminars and educational programs sponsored by medical or osteopathic schools, state or national medical or osteopathic societies, and national medical specialty boards. It also included programs by specialized CME provider which are reviewed and accepted by the Board. Category one is desireable in that it is the most organized of the CME categories where the sponsor makes the greatest effort to determine the learning needs of the audience. Of the 150 required hours of CME, at least 60 hours had to be of "category one"

quality. The remaining 90 hours of required CME could come from the other categories. There were specific limitations on how many hours of CME could be acquired in each of these categories. There was no limitation of the number of hours of "category one" CME that could be accepted in a 3 year cycle.

Implementation of the original rules showed that Category one activities were very beneficial, Category one activities are expected to be more likely geared to the needs of the audiences they are aimed at. It is reasonable, therefore, to maintain a relatively high requirement in Category one but to reduce the overall number of hours considered necessary for demonstration of competence.

Through the implementation of the rules, it has become apparent that a physician may acquire acceptable CME credits from the other categories as a function of his or her profession and would attend these functions with or without the CME requirement. For instance many physicians claim the maximum number of category two hours through attending local hospital medical staff meetings and claim the maximum number of category five hours through medical journal readings. However, those physicians who are unable to meet the CME, seem to lack access and rarely claim any hours in categories two through five. There seems to be a polarization between these physicians who easily exceed the limits for categories two through five and those who are unable to obtain any hours in these categories. Since access to these categories is not particularly difficult, expecially for the medical staff meetings (in category 2) and the medical journals (in cagegory 5),

one could assume that the problem is familiarity. Once a means of access is established it seems that most physicians greatly exceed the ceiling established by the CME rules.

The Board recognizes the value of categories two through five, however since most physicians naturally take more of these activities than they could claim credit, the maximum levels which could be claimed under these categories does not seem appropriate. It would seem reasonable that the overall CME hour requirement could be reduced by lowering the maximum number of hours which could be claimed under categories two through five, without risking any harm to the public or lowering the level of medical care. As is the care currently, it will be assumed that physicians will still attend and use the activities beyond the current and proposed limits placed upon these categories. However a reduced maximum on these categories, coupled with an appropriate reduction in the total requirement, will still serve the purpose of encouraging these physicians not familiar with categories two through five to learn about them.

1. "60" HOURS OF CREDIT SHALL" HAS BEEN DELETED FROM THE RULES AND "45 HOURS OF CREDIT MUST" HAS BEEN ADDED IN ITS PLACE.

   The most basic principal which this entire rule is trying to achieve is to emphasize the dominance of category one activities. This change is reasonable and consistant with the above philosophy and does serve in the best interest of the public. An article by Leonard S. Stein, M.D. (Journal of Medical Education, February 1981) surveys various CME provision situations and forms a conclusion that CME does not change physician behavior. The conclusion is based upon the tendency of physicians to assimilate advanced medical practices, treatments, drugs, etc., which are

presented at CME activities that are organized so as to identify the learning needs of the audience, establishes clear goals and objectives, uses relevant learning methods, and evaluates the effectiveness of the programs. It is reasonable to assume that the patient would benefit from learning new and advanced medical techniques. Although the physician may not wish to perform a new technique learned at a CME activity, the physician would be able to diagnose the proper time to apply the new technique and could refer the patient to the appropriate specialist. Without attending the CME activity or by attending a CME activity without the proper educational controls the physician might have used a less advanced (and perhaps inferior) techniques on the patient. The article by Stein is attached to the appendix.

2. *"45" (HOURS) HAS BEEN DELETED FROM THE RULES AND "20" (HOURS) HAS BEEN ADDED IN ITS PLACE.*

The Board recognizes that category 2 activities are beneficial medical learning experiences, however the Board also realizes that most physicians could obtain an unlimited number of CME credit hours under this category. All physicians who have hospital staff privileges could attend an endless number of medical staff meetings. Also physicians could create bogus medical associations for the purpose perpetrating category two activities for themselves. The limitation of twenty hours is reasonable in that it will encourage physicians to seek out those category two activities which are particularly relevant to their practice.

3. *"45" (HOURS) HAS BEEN DELETED FROM THE RULES AND "20" (HOURS) HAS BEEN ADDED IN ITS PLACE.*

The Board recognizes that category 3 activities are beneficial medical learning experiences, however the Board also realizes that those physicians in medical or health care education could obtain an unlimited number of CME credit hours through the function of their regular employment. The limitation of twenty hours is reasonable in that it will still encourage those physicians not directly employed in medical or health care education to seek this type of activity on a part-time basis outside of their practice, while those physicians employed in medical or health care education will be encouraged to seek other forms of continuing medical education in subject areas which will enhance the scope of their teaching.

4. *"40" (HOURS) HAS BEEN DELETED FROM THE RULES AND "20" (HOURS) HAS BEEN ADDED IN ITS PLACE.*

The Board recognizes that category 4 activities are beneficial medical learning experiences, however the Board also realizes that those physicians in medical research or education could obtain an unlimited number of CME credit hours through the function of their employment. The limitation of twenty hours is reasonable in that it will still encourage those physicians not directly employed in medical research or education to seek this type of activity on a part-time basis outside of their practice, while those physicians employed in medical research or education will be encouraged to seek other forms of continuing medical education in subject areas which will expand the scope of their knowledge.

5. "45" (HOURS HAS BEEN DELETED FROM THE RULES AND "20" (HOURS) HAS BEEN ADDED IN ITS PLACE.

The Board recognizes that category five activities are beneficial medical learning experiences, however the Board also realizes that those physicians in medical research could obtain an unlimited number of CME hours through the function of their regular employment. The limitation of twenty hours is reasonable in that it will still encourage those physicians not directly employed in medical research to seek this type of activity on a part-time basis outside of their practice, while those physicians employed in medical research will be encouraged to seek other forms of continuing medical education in subject areas which will expand their medical knowledge.

C. "APPROVAL OF COURSES FOR CREDIT" LOCATED BETWEEN B.5. AND C. HAS BEEN DELETED AND "APPROVAL OF COURSES FOR CATEGORY ONE CREDIT" HAS BEEN ADDED IN ITS PLACE AT THE BEGINNING OF SUB-SECTION C.

Since Sub-section C. refers to the approval for category one credit it is reasonable that this statement be moved up to sub-section C to serve as the sub-section title. It is reasonable to add the category one qualification, in that it is the only category covered in this sub-section and it is the only category which these rules give the Board the authority of approval.

D. SUB-SECTION D. ESTABLISHES THE GUIDELINES UNDER WHICH THE BOARD SHALL GRANT CATEGORY ONE CME CREDIT. ALTHOUGH SUB-SECTION D. REMAINS THE SAME, A MINOR TECHNICAL CHANGE WAS MADE IN ONE ITEM UNDER SUB-SECTION D.

1 - 5. No change

6. "BOARD" WHEN IT IS USED IN THE CONTEXT OF NATIONAL SPECIALTY BOARD HAS BEEN DELETED AND "SOCIETY" HAS BEEN ADDED IN ITS PLACE.

National specialty boards are organizations which administer examinations that will certify a physician as being competent in a given specialty, this is their main function. However, medical specialty societies are more diversified organizations, they would provide more services for their members and would be much more likely to provide CME activities. Because they are the more likely CME providers it is necessary and reasonable that they be listed as category one CME providers and not the medical specialty boards, who basically have little to do with CME activity provision.

E. No Change.

F. "THE BOARD MAY ALSO ACCEPT CERTIFICATION OF OTHER STATE OR NATIONAL MEDICAL GROUPS WHOSE CONTINUING MEDICAL EDUCATION REQUIREMENTS ARE THE EQUIVALENT OF OR GREATER THAN THOSE OF THIS BOARD IN LIEU OF COMPLIANCE WITH THESE STANDARDS" HAS BEEN MOVED FROM SUBSECTION F TO SUBSECTION H (SUBSECTION G ON THE REVISED RULES).

This provision is a means of permitting physicians to provide evidence of having met the CME requirements in the event of an audit by the Board of the physician's CME activities. Therefore it is reasonable that this sentence be moved to subsection ~~H.~~ G. which authorizes the discretionary use by the Board of requesting evidence of having actually completed the CME activities.

G. THE ENTIRE SUB-SECTION HAS BEEN DELETED.

This section refers to the retroactive approval of CME activities taken prior to January 1, 1977. Sicne these activities are no longer applicable to current or future CME reporting cycles, it is reasonable that this section be dropped.

H. "H" HAS BEEN CHANGED TO "G".

Since G. has been omitted completely, it is reasonable that this subsection be shifted up to G.

I. "I" HAS BEEN CHANGED TO "H".

Since G. has been omitted completely it is reasonable that this sub-section be shifted up to H.

1. "1" HAS BEEN ADDED TO WHAT WAS THE SOLE EXEMPTION IN THE ORIGINAL RULES.

Since a second exemption has been added to sub-section ~~I.~~ H. it is reasonable to call this exemption item 1.

2. "PHYSICIANS UNDER THE EMERITUS REGISTRATION STATUS AS PROVIDED IN 7 MCAR § 4.013 ARE EXEMPT FROM THESE CONTINUING MEDICAL EDUCATION REQUIREMENTS OF THIS RULE." HAS BEEN ADDED.

"Under 7 MCAR § 4.013 (Emeritus Registration-Retired Physicians) it is stated that the Continuing Medical Education requirements do not apply to the emeritus physician status. Therefore, it is reasonable that the physician emeritus status be listed as an exemption to the rule.

J. "J" HAS BEEN CHANGED TO "I".

Since G. has been omitted completely it is reasonable that this sub-section be shifted uptto I.

APPENDIX

The Effectiveness of Continuing Medical Education. Eight Research Report by Leonard Stein, Ph.D., Journal of Medical Education, Vol. 56, February 1981.

Reading Lecture
Saturday morning

The Effectiveness of Continuing Medical Education: Eight Research Reports

Leonard S. Stein, Ph.D

Abstract—Continuing medical education has been widely criticized as ineffective; most such criticism is directed at the assumption that the mere transmission of information on new research findings is sufficient to change physician performance. Eight studies published during the 1970s report changes in physician behavior (and, in one, improved patient outcomes) as a result of CME organized on sound educational principles, including systematic effort to evaluate program effectiveness and learner achievement. It is also suggested that additional information on CME effectiveness is likely to be obscured by the form in which much medical literature is presented.

A variety of factors and forces are responsible for the astonishing improvements in medical care since World War II—among others, the enormous investment in biomedical research; emergence of new medical specialties and subspecialties and new paraprofessional occupational titles; and new facilities. Organized continuing medical education (CME) developed as a significant physician response to these rapid changes and in turn has become a causative factor in its own right toward the achievement of optimal patient care.

Traditionally, CME has aimed to help "keep up"—that is, inform practitioners about new research findings on the grounds that the mere transmittal of this information would ensure changes in clinical performance (1). There is no disagreement that practitioners need to learn about and use new Dx/Rx modalities as their efficacy is proved, but there has been strong criticism of the view that the mere transmittal of facts about new findings is sufficient to change practice performance, for example, Miller (2) in 1967, Fleisher in 1970 (3), Meyer (4) and Pellegrino (5) in 1975, and Stern (6) in 1976.

This criticism is based on a series of reports that show little effect on physician behavior as a result of participation in formal CME programs. Note, for example, the literature review by Bertram and Brooks-Bertram (7). The growth of quality assurance procedures has offered further support for this criticism, suggesting that the bulk of deficiencies in patient care attributable to physicians is not the result of insufficient knowledge. For example, Ashbaugh and McKean (8) reviewed 55 audit studies in two Idaho hospitals and discovered that only 6 percent of physician deficiencies resulted from lack of knowledge.

A particularly unhappy aspect of traditional CME is the belief that physicians easily assimilate whatever is presented to them and, therefore, that there is no need to assess program effectiveness. As early

Dr. Stein is executive director, Illinois Council on Continuing Medical Education, Chicago.

as 1968 Abrahamson (9) criticized the lack of rigorous scientific procedures in CME evaluation. Greenberg and co-workers (10) surveyed 140 CME courses in surgery offered during 1975–1976 and found that none made any effort to assess physician learning. Lloyd and Abrahamson (11) reviewed the CME literature for the period 1966–1977 and found only 47 studies published in English that utilized an objective method of evaluation—of which only 23 could demonstrate changes in physician knowledge, competence, or performance, or effect on patient care; only 14 reported a statistically significant difference before and after the educational intervention, and eight of these measured only changes in knowledge.

Effect of Criticism

In the absence of valid data, it is of course impossible to judge the usefulness of CME in achieving optimal patient care. The volume of criticism and the credibility of its sources, however, were sufficient to persuade practitioners to take the criticism seriously. In 1976 the Nebraska Board of Examiners in Medicine and Surgery supported a revision of the state licensure law that authorized the board to impose a CME requirement for license renewal; subsequently, it chose not to exercise the authority because board members could perceive no relationship between CME and maintenance of physician competence (12). Three years later the Medical Association of Georgia officially objected to mandatory CME on the same grounds (13).

The arguments against mandatory CME were perhaps most eloquently articulated in 1976 by Wells (14): "... We have thus far found no way to demonstrate or measure improvements in the practice of medicine as a result of educational efforts. Moreover, we have yet to develop objective methods to determine educational needs ... CME remains essentially experimental and pragmatic both in method and content."

Wells makes clear, however, that he defines "CME" in the traditional manner—the mere transmittal of facts—in remarking, "The basic problem of CME ... is not the transference of scientific concepts but the alteration of human behavior. This is a challenge few of us have consciously faced in the past."

The Challenge Confronted

As suggested by the dates noted, criticism of CME reached its peak during the 1970s. That decade also saw the publication of eight studies that reported changes in physician performance as a result of additional learning, including one that also reported improved patient outcomes.

The following eight studies* appeared in North American medical journals between 1973 and 1979:

"Measuring the Effectiveness of Continuing Medical Education" by R. M. Caplan (15).

"Patient Referrals: A Behavioral Outcome of Continuing Medical Education" by J. M. Mahan, B. U. Philips, and J. J. Constanzi (16).

"Effects of Continuing Medical Education on Practice Problems" by R. C. Talley (17).

"Improved Perinatal Knowledge and Care in the Community Hospital Through a Program of Self-Instruction" by J. Kattwinkel, L. J. Cook, G. A. Nowacek, H. H. Ivey, and J. G. Short (18).

"Continuing Medical Education at Stanford: The Back-to-Medical School Program" by E. Rubenstein (19).

"Improved Outcomes in Hypertension

* The eight have been reproduced in a handbook by the Illinois Council on Continuing Medical Education, Chicago, with permission of the respective publishers and authors, under the title, *Physicians Improve Performance Through Continuing Education.*

After Physician Tutorials: A Controlled Trial" by T. S. Inui, E. L. Yourtee, and J. W. Williamson (20).

"Improving Physician Performance by Continuing Medical Education" by O. E. Laxdal, P. A. Jennett, T. W. Wilson, and G. M. Salisbury (21).

"Evaluation of Continuing Medical Education for Chronic Obstructive Pulmonary Diseases" by V. L. Wang, P. Terry, B. S. Flynn, J. W. Williamson, L. W. Green, and R. Faden (22).

Four tests were applied to select these eight reports: (*a*) Each is an educational case study that described a learning problem for a defined group of physicians and the educational intervention undertaken to deal with the problem. (*b*) Methodology used for analysis of data displayed face validity; preferably statistically significant objective data are reported. (*c*) A clinically important change in physician performance was reported. (*d*) The reported change persisted for at least six months.

The eight studies were identified primarily through a review of the *Journal of Medical Education*, including its monthly bibliography. Footnotes in other journals led to identification of two; a colleague brought one to the author's attention.

Summary of Studies

For purposes of this review the eight are categorized by the apparent reason for initiating the CME programs described.

PHYSICIAN INITIATIVE

Caplan (15) reports on a family practice review course at the University of Iowa in 1971, during which 60 physicians elected a 40-minute workshop on tonometry. A precise educational objective was formulated: " ... demonstrate in a laboratory setting ability properly to perform tonometric examination upon either a plastic model of the orbit, or upon a fellow student." The standard of performance set by the ophthalmologist-instructor was that there should be "no improper or unsafe use of the instrument" and that the value determined by the learner must agree with that obtained by the instructor within 2 mm of pressure. The evaluation measure used was a six-month postconference questionnaire, to which 41 participants responded. The most significant finding was that of 11 registrants who did not own a tonometer when they took the workshop, 10 purchased one thereafter. The 41 respondents also reported regular tonometric examinations in routine physical examinations on patients over 39 years old.

Mahan and co-workers (16) describe a seminar offered by the Cancer Center of the University of Texas Medical Branch (Galveston) for interested medical staffs at hospitals in east and south Texas. The learning goals dealt with knowledge (help learners become "more aware of research and clinical progress" and "illustrate ... that cancer is a multidisciplinary disease ... "), attitudes ("show the primary care physician as an important part of the cancer team" and "develop within the physician a positive attitude toward the aggressive treatment of suspected malignancy"), and clinical performance (learn "procedures which the primary care physician could follow to ensure proper diagnosis and treatment ... "). Four medium-sized hospitals were selected to test the hypothesis that "the most robust measure of program effectiveness ... would be ... referrals." The seminar was offered to two of the four; once the seminar was scheduled, interested physicians could choose to attend and, if they wished, to present their own cases for review by the visiting experts. Referrals from these two hospitals increased from 26 during the year before the seminar was offered to 69 in the year following (statistical significance at hospital one at the .1 percent level and at hos-

pital two at 1 percent). By contrast, referrals from the two control hospitals—located at about the distance from UTMB—remained at nine for both years.

Talley (17) reports one ideal kind of CME. Confronted with a problem (lack of use of sophisticated cardiac monitoring equipment), the medical staff of a 350-bed community hospital in South Dakota consulted the Department of Internal Medicine at its state university School of Medicine. The result was a five-hour course that was offered also to interested physicians at a nearby hospital of the same size. Twenty-eight family physicians, internists, and surgeons registered; the course was offered three times so that enrollment could be kept at 10 or below for each session. Course work included lectures and self-assessment tests, laboratory work on pulmonary artery monitoring utilizing dogs and the hospital's own monitoring equipment, and group discussion of possible complications and indications for use. Among the registrants were both physicians who planned only to refer patients for balloon flotation catheterization and clinicians who would actually perform the procedure. During the seven months prior to the course, 43 patients had pulmonary artery pressure monitoring; this doubled during the subsequent seven months to 87.

UNIVERSITY INITIATIVE—SERVICE

Kattwinkel and co-workers (18) begin with the admission that traditional CME offered to community hospitals by the University of Virginia perinatal center had failed to improve the quality of care provided to infants and mothers at risk in referring community hospitals. The university's Department of Pediatrics, therefore, designed an elaborate plan by which a community hospital could analyze the performance of its medical staff, nurses, and others involved in perinatal care: an inventory of personnel, facilities, and hospital policies or procedures; a self-assessment test; and an attitude questionnaire. The primary educational intervention consisted of a 600-page self-instruction program covering 19 subject-areas and 20 skills; specific content varied among hospitals in accord with each institution's self-identified needs. In addition, special skills sessions were conducted by each hospital's educational coordinator, and university faculty conducted a three-hour workshop on endotracheal intubation and umbilical catheterization half-way through the self-instructional period. Learning goals focused on knowledge and skills directly and indirectly on changes in attitude and procedures. Nine community hospitals accepted the invitation to participate in the program. Evaluation measures used were program acceptance measured in part by completion rate of the self-study manual (number of tests submitted), facilities change, attitudinal change, gain in cognitive knowledge, and changes in care practice measured by chart review and analysis of pretransport activity for infants referred to the university perinatal center. Results showed statistically significant improvements in knowledge, attitudes, and performance.

Rubenstein (19) describes a complex relationship between the Stanford University School of Medicine and five nearby community hospitals, including a compressed review of the entire medical curriculum offered in Mills Memorial Hospital, San Mateo. Each course met for an hour a week and focused on the kind of patient problems confronted by Mills GP/FPs, internists, and pediatricians. Faculty was drawn from both the university and the hospital. The format—formal courses—"made it possible to incorporate those educational techniques related to the repetition, correlation, and integration of information." Evaluation consisted of

chart review, and the author reports a series of process improvements during the first two years of the Mills program that were statistically significant; for example, decrease in use of whole blood and increase in use of packed cells for anemic patients not actively bleeding; discontinuance of the outmoded Lee-White clotting time test and adoption of the partial thromboplastic time test; increase in intravenous administration of heparin and decrease in subcutaneous administration.

UNIVERSITY INITIATED—RESEARCH

Primary purpose of the remaining three studies was to test hypotheses about effective CME methods related to improvement of physician performance.

Perhaps the most interesting is that by Inui and associates (20). They determined that physicians in an outpatient clinic were correctly diagnosing and treating hypertension but that the blood pressure of a substantial proportion of patients was nonetheless uncontrolled. Interviews with patients revealed that they were not complying with the sound medical advice offered because of ignorance about organ impairment and other dangerous consequences of essential hypertension and the value of prescribed medication and diet. Educational intervention consisted of a one-to-two–hour tutorial with half the physicians, focused on the "Health Belief Model" (23). Evaluation utilized chart review, with these outcomes: (*a*) Physicians who participated in the brief tutorial shifted their clinical behavior to spend more time on patient education and counseling and less on symptomatology. (*b*) Patients who saw these physicians began to comply with the prescribed regimen; more important, their blood pressure dropped to acceptable levels. The differences between physicians who engaged in the tutorials and those who did not, and between the patients of each set of physicians, were statistically significant at very high levels of probability.

The final two studies illustrate two different approaches to needs-identification.

Laxdal and associates (21) identified 55 frequent "prescribing problems" and then invited groups of physicians in community hospitals near the University of Saskatchewan to determine whether any on this list were occurring in their respective hospitals. Each interested group then selected a few of the listed problems, formulated relevant behavioral objectives, and engaged in both individual and group learning activities with the assistance of the university. The evaluation procedure was chart review; on five prescribing problems common to both experimental and control hospitals, the authors report improvement in both sets of hospitals. Change in the experimental group, however, was twice as great (62.7 percent of overall possible improvement) as in the control hospitals (32 percent)—a highly significant statistical difference.

Wang and co-workers (22) began instead by selecting patients suffering from or at risk of chronic obstructive pulmonary diseases and then identified their primary care physicians. The 350 physicians so identified were invited to participate in a CME program; 178 agreed and 144 actually did so. The educational intervention included a self-assessment test of cognitive knowledge, small-group discussions, and two self-study audiovisual packages. Evaluation procedure consisted of a cognitive test of knowledge gained and a follow-up questionnaire on changes in practice, with these results: (*a*) Participating physicians exhibited gain in knowledge about COPD to the same level as that of pulmonary specialists. (*b*) These clinicians also reported statistically significant increase in use of correct antibiotics and decrease in prescription of inappropriate medications.

Common Study Characteristics

Analysis of the eight studies shows that all utilized—implicitly or explicitly—the four essential elements of any effective learning program:

Identified learning need, specified audience—In each case some deficiency existed that could be corrected through additional learning. Three of the studies defined specific groups of physicians with the identified need; four announced the problem(s) and invited clinicians to participate in a learning program; the eighth (18) provided necessary tools and invited physicians and nurses in community hospitals to identify their own learning needs. In all eight studies three points marked the needs-identification and audience-specification process: emphasis on patient need, use of small groups, and involvement of the learners in the needs-identification process and program planning.

Clear goals and objectives—In each report the learning to be achieved was clear to all concerned—either expressed explicitly in the form of educational goals and/or objectives or implicitly as a clear definition of the problem or learning need.

Relevant learning methods, emphasis on participation, clinical setting—Aside from other considerations (for example, the research concerns of the Laxdal, Kattwinkel, and Wang groups), in each case the central focus was on improving patient care—that is, on changing physicians' clinical performance—rather than on gain of knowledge. Accordingly, strong learner participation marked the educational intervention in each study, a method possible partly because small groups were involved (as few as four in two of the hospitals described by Laxdal and as many as 40 in one of the seminars described by Mahan). Seven of the eight occurred in a clinical setting (hospital or outpatient clinic), and the eighth report (15) simulated a clinical setting. From another perspective each educational intervention was conducted in a manner analogous to the normal interprofessional communication of physicians; all eight might be viewed as highly structured "corridor consultations."

Systematic effort to evaluate—In each case the author(s) began with an intention to assess learner achievement and program effectiveness. Each determined an initial baseline of performance (identified learning need); defined program goals and learning objectives explicitly or implicitly; and selected learning methods appropriate for the need(s), goal(s), and objective(s), and the audience. Thus, it was possible for each set of investigators to engage in systematic evaluation.

Six evaluation techniques/procedures were used in the eight studies; none is unusual or exotic: cognitive tests of knowledge gained, chart review, follow-up questionnaires, analysis of changes in referral patterns, attitudinal questionnaires, and audience reaction questionnaires and percentage of course or program completion. None relied exclusively on any one of these methods; none used all six. Several didn't bother with a cognitive examination (16, 21), utilizing instead records of actual performance (chart review or referrals). Those utilizing an audience reaction form did so only to determine learner satisfaction with the learning process (for example, Kattwinkel asked participants to complete five such forms during the course of the program to maintain sensitivity to audience concerns and interests); none relied on this device as a measure of learning achievement.

Discussion

It seems unlikely that these eight reports constitute the sum total of evidence that formal learning assists physicians to improve clinical performance. At least three other sources of such evidence suggest themselves: (*a*) A large number of clinical

studies report improvements in patient care resulting from adoption of new treatment modalities; implicit and almost never mentioned in such studies is the fact that some physicians had to learn how to use the new modality (for example, open heart surgery or correct drug regimen for hypertension) in order to conduct necessary clinical trials. (*b*) Various proposals for new approaches to CME include evidence on their effectiveness. Notable are the first two descriptions of Brown's "Bi-Cycle Concept," which report improvements in physician performance at Chestnut Hill Hospital; mention of these changes, however, is only incidental to the main thrust of each paper (24, 25). (*c*) Considering the enormous growth of inhospital CME over the past decade, it seems reasonable to believe that much evidence on the effects of organized CME is buried in reports of hospital staff committees.

A major problem that confronts those who seek evidence on the effectiveness of CME from the literature is that very few descriptions of CME activity are written in terms of the four major elements of the learning process (needs-identification, goals and and objectives, methods, evaluation). Indeed, of the eight papers described herein, three do not explicitly use this framework. Reviewing Index Medicus for 1977, Berg (1) found nearly 200 listings on CME, but over three fourths are editorial comments and nearly all the remainder report "how we do it at our place."

Especially lacking in much of the medical literature on improved patient care are analyses of physicians' learning needs. Typically, such reports describe a new Dx/Rx modality or report epidemiological data, implicitly assuming physicians' lack of competence or knowledge with respect to the clinical problem(s) presented. While the formulation of clear program goals and specific learning objectives in behavioral form enhances the learning process, in clinical medicine an accurate and specific description of physician learning needs or unsolved patient problems for a defined group of physicians or of patients at risk can also effectively define the educational intervention likely to correct the identified problem. Such precise definition of the problem also provides the necessary baseline from which to assess changes in performance and/or patient outcomes.

Failure to use the full four-part educational framework, however, can inhibit valid decisions on whether further learning or other measures are needed to improve physician performance and patient care. For example, among other outcomes reported by Kattwinkel and associates (18) was the purchase of new equipment and the renewed use of equipment on hand. Laxdal and colleagues (21) note that one problem confronted by the physicians they studied was slow laboratory service, a problem clearly insoluble through additional physician learning—although, as Brown points out, some additional training for laboratory personnel can be helpful (25).

Conclusion

A review of eight reports on well-planned CME programs demonstrates that when physician learning activities are organized on the basis of sound educational principles, CME can result in changed physician performance (and, presumably, improved patient care). While each study reports some transmission of factual information, didactic instruction alone was not deemed sufficient to achieve desired goals and objectives. Participative methods—including hands-on experience, small-group discussion, and self-study materials—were heavily used in the eight studies. A crucial factor in each study is that the learners recognized their need for improved performance and participated fully in needs-identification, planning the educational intervention, and evaluation of outcomes.

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EMERITUS REGISTRATION RULES
STATEMENT OF NEED AND REASONABLENESS
DRAFT 3

It is the opinion of the Board that neither 150 hours of Continuing Medical Education over three years in the original rules nor the 75 hours over three years in these rules are either unreasonable or unduly restrictive. In administrating the old rules we have found that no doctor who had taken the effort to understand the rules and attempted to accumulate CME credits has fallen short in the number of hours necessary for relicensure. With the evaluation of CME, various formats have proliferated, including various category one self-teaching devises (video, tapes, reading material) for physicians who may be incapacitated due to illness or accident. Indeed an informed physician, admitted to a hospital, would find unlimited access to category 1, 2, and 5 activities.

Although the Board feels that the CME requirements are not unduly restrictive or harsh, it appears that the requirements are unreasonable for physicians who had been retired for several years before the original rules were promulgated. It should be pointed out that the concept of CME is totally foreign to these doctors, they had gone through their entire professional careers without having to attain CME's and in many cases had been able to retain their licenses during their retirement without worrying about CME's. Now suddenly if they wished to retain their licenses they had to meet a CME requirement. Confronted with this CME requirement, many of the physicians in this situation allowed their licenses to lapse.

The effect of this on these physicians was in many cases devastating. Although a license lapse is not the same thing as licensure suspension, many doctors looked upon the situation as if their licenses had been suspended.

In an editorial of the March, 1979 issue of Minnesota Medicine, Carl O. Rice, M.D., Ph.D., made the following comments, "abrogation of a doctor's license is generally regarded as tantamount to unethical conduct on his (sic) part - a fall from grace with a subtle implication, insinuation, or innuendo of treason or heresy...we would resent being equated or identified with those practitioners who have violated their commitment (to medicine) and thereby forfeited their privilege to practice." The distinction between revocation and a lapse, which a doctor could make up at his or her own discretion by complying with the CME requirements, doesn't mean much to retired physicians like Dr. Rice. In either case they are being told that they may no longer practice medicine, they don't care about the name given to the action. Dr. Rice goes on to say that, "Revocation (sic) of our licenses would appear to brand us 'seniors' as non-doctors, as has-beens, canceling out our long and meritorious service... at retirement it would be difficult to face up to the humiliating psychic trauma that loss of licensure would entail. It would seem like exile to a Gulag archipelago." In a petition dated June 25, 1979 to the Board of Medical Examiners requesting that rules similar to the rules being argued for in this document be adopted, John J. Ryan, M.D. and John J. Ryan, III, make the following statements, "The license becomes significant... because the physician's entire professional career is represented by holding of the license... Beyond conferring permission to practice, the license symbolizes and in effect becomes, the professional status of the physician his career, competency, and acheivements. To take away the license of the retired physician is to deny him his right to self-esteem, professional reputation in the community and among collegues. In short, this memorial of his career is a property right and to have it withheld after retirement for not fulfilling the requirements of continuing education, is fundamentally unfair and inconsistant with sound board policy. The effect is disciplinary in nature and indistinguishable from revocation or suspension for malpractice, malfeasance or criminal conduct.

Non-renewal of the license, therefore, creates a stigma on the retired physician, casting his career and reputation in a negative light. This is an unjustifiable situation."

It should be pointed out that all physicians licensed to practice medicine in Minnesota are required to meet the Continuing Medical Education requirement. However, as stated above, the CME's proved difficult to the retired physician, in that they went decades without having to meet this requirement, but were suddenly having it foisted upon them in retirement. As a result over the last several years since the original CME rules were promulgated, the Board has received countless letters and phone calls from retired physicians, embittered and frustrated over having to meet new CME requirements or else face the loss of their license to practice. Confronted with the CME requirement, most retired physicians in this situation allow their licenses to lapse but in the process express their concern and disappointment to the Board. Typical of these correspondences, although more diplomatic than most, is a letter dated October 2, 1981, from Dean D. Nywall, M.D., of Slayton, Minnesota. In his letter Dr. Nywall states, "it took 20 years from high school till I finished my internship, to aquire my M.D., and I have practiced for 30 years... You have your rules I know, but as I've stated I have no intentions, for reasons of future health, of ever practicing medicine again. I would just like to continue to feel that I am a doctor of medicine."

Essentially, these physicians believe they are not able to renew their medical licenses and have no prospect of retaining anything which will show the years in which they actively practice medicine. What the Board proposes to do is to establish, at a minimal cost, an emeritus registration for retired physicians as a means of bridging this problem.

Under the emeritus registration the public would still be protected in that the retired physician could not practice medicine or prescribe drugs, but the

emeritus registration certificate would show that the doctor had completed his medical career in good standing with the Board. This is important to the retired physician as it emphasizes the fact that his or her license has not been suspended and the physician has the option of reinstating his or her license by complying with the CME requirements stipulated in this rule.

The emeritus physician registration would represent a new expense for the Board, however it would be self-sufficient. The major coast to the Board would be:

1. *Cost of processing applications for emeritus registration. This should not be a major cost, essentially referring to the doctors' files to make certain that the physician's medical practice has been without disciplinary action. The Board could probably expect a large number of physicians applying for the emeritus registration when the rules are first promulgated, however it would be reasonable to expect the number of emeritus registration applications to tail off. After the initial applications, the burden to the Board in terms of staff time and cost would not be great.*
2. *At a cost of one-fourth of the regular licensure fees for physicians (one fourth would currently be five dollars), if he or she wishes the physician may obtain a certificate signifying ones registration as a physician under the emeritus registration. This should be sufficient to cover the Board's expenses. (Attached at the end of the statement is a memo explaining how the fee was arrived at.)*
3. *The Board would be responsible for the policing of the emeritus registrant to insure that they do not practice medicine and prescribe drugs, and to take appropriate action when they do. Although this is a legitimate expense the surveilance of unlicensed physicians is something the Board would have to perform whether or not the emeritus reg-*

istration rule is promulgated.

4. *The Board will also process the reinstatement of the emeritus physician registrant to active licensure. This is another expense that the Board would have no matter what, as the Board would be processing reinstatements of retired physicians whether they are on inactive status (as they are now) or physician emeritus status. This is an expense which is covered by the annual licensure fee.*

Thus it would seem reasonable that these rules could be promulgated, which will help the retired physicians, without endangering or providing unnecessary expense to the public.

7 MCAR §§ 4.013 EMERITUS REGISTRATION-RETIRED PHYSICIAN (This entire section is new)

A. ANY PHYSICIAN DULY LICENSED TO PRACTICE MEDICINE IN THE STATE PURSUANT TO MINN. STAT. §§ 147.01 EQ. SEQ., WHO DECLARES THAT HE OR SHE IS RETIRED FROM THE ACTIVE PRACTICE OF MEDICINE MAY APPLY TO THE BOARD FOR PHYSICIAN EMERITUS REGISTRATION. THE PHYSICIAN MAY DO SO BY INDICATING ON HIS OR HER ANNUAL REGISTRATION FORM OR BY PETITIONING THE BOARD IF HE OR SHE IS IN FACT COMPLETELY RETIRED AND HAS NOT BEEN THE SUBJECT OF DISCIPLINARY ACTION RESULTING IN THE SUSPENSION, REVOCATION, QUALIFICATION, CONDITION, OR RESTRICTION OF THE PHYSICIAN'S LICENSE TO PRACTICE MEDICINE."

It is reasonable that this rule only apply to those that are completely retired, those who are not completely retired and who are still practicing in any extent would be required to retain their regular licenses to practice medicine. Since the emeritus registration is essentially an honorary commemoration for those physicians who have completed their medical careers in good standing with the Board, it is reasonable that this registration not

be made available to those physicians who have been the subject of disciplinary action resulting in the suspension, revocation, qualification, or restriction of their licenses.

B. THE EMERITUS REGISTRATION IS NOT A LICENSE TO ENGAGE IN THE PRACTICE OF MEDICINE AS DEFINED IN MINN. STAT. §§ 147.10 OR IN THE RULES OF THE BOARD. THE REGISTRANT SHALL NOT ENGAGE IN THE PRACTICE OF MEDICINE.

Since the physician registered as emeritus does not have to meet the licensure requirements, which certify one's capacity to practice medicine, and since the physician under the emeritus registration has declared him or herself as being retired, it is reasonable and in the best interest of the public that the emeritus registration not be considered as a license to practice medicine.

C. THE CONTINUING MEDICAL EDUCATION REQUIREMENTS OF 7 MCAR §§ 4.012 ARE NOT APPLICABLE TO EMERITUS REGISTRATION.

Since the emeritus registration is not a license to practice medicine it isn't reasonable to require the physicians under the emeritus registration to meet the Continuing Medical Education requirements.

D. A REGISTRANT WHO DESIRES TO CHANGE TO ACTIVE STATUS MAY DO SO BY PROVIDING THE FOLLOWING MATERIALS, PENDING THE APPROVAL OF THESE MATERIALS BY THE BOARD.

It is conceivable that a physician on emeritus status may eventually wish to convert back to a regular license, so as to be able to practice medicine or prescribe drugs again. It is reasonable for the Board to set up a procedure for the reinstatement of these physicians, and to set up various requirements which need to be met to insure that the physician has the capacity to practice medicine competently.

1. COMPLETION OF A FORM PREPARED BY THE BOARD WHICH INCLUDES NAME, BASIC MEDICAL EDUCATION, MEDICAL LICENSE NUMBER, DURATION OF MEDICAL LICENSURE, DATE OF EMERITUS REGISTRATION, MEMBERSHIP IN MEDICAL

SOCIETIES, INFORMATION ON THE APPLICANT'S PHYSICAL AND MENTAL HEALTH, AND INFORMATION ON ANY DISCIPLINARY ACTION TAKEN AGAINST THE PHYSICIAN IN REGARDS TO HIS OR HER MEDICAL PRACTICE.

It is reasonable for the Board to stipulate that the physician complete a form which covers the events which occured during the time the physician was on the emeritus registraion to insure that nothing occurred that would effect the physician's ability to practice medicine. The questions on the form specified in the rule would provide information on the physician's medical licensure and activities during the emeritus registration to ensure that the that the physician has retained the capacity to practice medicine.

2. COMPLYING WITH THE CONTINUING MEDICAL EDUCATION REQUIREMENTS FOR THE TIME PERIOD IN WHICH ONE'S LICENSE WAS IN INACTIVE STATUS AND UNDER THE EMERITUS REGISTRATION PURSUANT TO 7 MCAR §§ 4.012.A. THIS REQUIREMENT MUST BE FULFILLED PRIOR TO SUBMISSION OF THE APPLICATION.

It is reasonable for the physician on the emeritus registration wishing to revert back to a license to practice medicine and to comply with the Continuing Medical Education requirements which apply to other licensed physicians. It is reasonable that the CME's be completed prior to submission of the application, so as to prevent abuse of the rule by doctors who might obtain their reinstated license and use it without any intent of complying with the CME requirements. The CME rules were establisehd as a means of up-grading the educational level and medical skills of the physician and keeping the physician abreast of advances in the medical profession. With the intent of the CME rules in mind, it would not be fair to the patients to permit a physician to re-enter the profession without the Continuing Medical Education background of other physicians.

3. SUBMISSION OF ALL BACK LICENSURE FEES WHILE ONE'S LICENSE WAS UNDER INACTIVE STATUS AND THE EMERITUS REGISTRATION.

It is reasonable for the physician on the emeritus registration wishing to revert back to the regular license to practice medicine to submit

the licensure fees that other licensed physicians in Minnesota have to submit. The requirement of paying all back licensure fees discourages the practice of continual licensure status changes by the physician which places an extra burden upon the Board's staff. The payment of back licensure fees would also help to defer the cost of the reinstatement procedures. Establishing this requirement which will encourage physicians to retain their medical licensure will be beneficial to the public in that it will lead to a larger base of qualified, licensed physicians in the state.

4. SUBMISSION OF REFERENCES BY TWO PHYSICIANS LICENSED TO PRACTICE MEDICINE IN MINNESOTA VERIFYING THAT THE REGISTRANT HAS THE CAPACITY TO PRACTICE MEDICINE; AND

It is reasonable for the Board to stipulate that the physician on emeritus status wishing to reinstate his or her license to practice medicine to provide two references from licensed medical doctors. It is vital that before a physician is re-issued a license to practice medicine that the physician is capable of practicing medicine and wouldn't present a risk to the public. These two doctors would understand the practice of medicine and would be able to confirm if the applying doctor still had the capacity to practice medicine.

5. SUBMISSION OF A NOTARIZED, COMPLETED, AND SIGNED INFORMATION RELEASE FORM, LISTING ALL SCHOOLS ATTENDED, HOSPITALS AND CLINICS SERVED AT, AND BRANCH OF MILITARY SERVED IN.

It is reasonable for the Board to have access to education, work and military background of a physician on the emeritus registration requesting a reinstatement to his or her regular license, if such information is necessary for the Board in rendering a decision in regards to reinstatement. In that a long period of time may have passed since the reinstating physician was originally licensed, it is important that the Board have access to those records in order to make certain that the physician is still eligible for licensure. The information release form will provide access to this information.

E. A PHYSICIAN GRANTED EMERITUS PHYSICIAN REGISTRATION SHALL, UPON PAYMENT OF A FEE, RECEIVE A DOCUMENT CERTIFYING THAT HE OR SHE HAS BEEN REGISTERED AS EMERITUS AND HAS COMPLETED HIS OR HER ACTIVE PROFESSIONAL CAREER LICENSED IN GOOD STANDING WITH THE MINNESOTA BOARD OF MEDICAL EXAMINERS. THE FEE FOR SUCH A DOCUMENT SHALL BE FIVE DOLLARS. THE DOCUMENT FEE SHALL NOT BE A PREREQUISITE FOR CONSIDERATION OF AN APPLICATION FOR EMERITUS REGISTRATION.

If the physician wishes to receive a document certifying that he or she is a physician under the emeritus registration it is reasonable that he or she should receive a document assuming the physician is willing to submit a fee for the document. The fee is set at one-fourth the cost of a license to practice medicine so as to cover the cost of the document. For further discussion on why the registration fee was set at five dollars, please see the appendix.

However if the physician doesn't want to spend the money on the document neither the document nor the fee should be considered necessary for the emeritus registration.

F. BEING REGISTERED AS EMERITUS WILL NOT SUBJECT A PERSON TO THE ANNUAL RENEWAL CYCLE OR RENEWAL FEES.

Since the emeritus registration doesn't contain any privileges for practicing medicine, there would be no need for a periodic review of the physician's registration in order to insure that he or she still has the capacity or competence to practice medicine. The only ways in which the emeritus registration could be terminated is if he or she attempts to practice medicine or if he or she wishes to be eligible to revert to a regular license to practice medicine. There are no other reasonable needs in which the emeritus registration should be terminated.

APPENDIX

The following materials were sent out in regards to the application fee for the emeritus registration:

A. Memo to the CME Committee of the Board Examiners making a recommendation for registration fee and rational for the fee.

B. After this fee was approved by the CME Committee this memo was sent to the entire Board, requesting a vote by the entire Board. Memo A was enclosed with this memo.

C. Individual mail votes by the CME Committee and the entire Board in regards to the approval of the five dollar emeritus registration fee. CME Committee members vote as part of the whole Board stayed the same as their Committee vote, unless they expressed a change in opinion.

D. Application to establish a licensure fee to the Commissioner of the Finace Department.

E. Memo of December 22, 1982, from Allen A. Yozamp to Jack Wallace rejecting the emeritus registration fee of five dollars.

F. Memo of February 15, 1983 from Jack Wallace to Allen A. Yozamp, responding to the objections raised by the Department of Finance responding to the objections raised by the Department of Finace to the five dollar emeritus registration fee.

G. Memo of March 3, 1983 from Allen A. Yozamp to Jack Wallace approving the emeritus registration fee.

H. Authorization from Dean D. Nywall to use quote in this document. (all other quotes were from public documents)

A

SF 00003-02

STATE OF MINNESOTA

Office Memorandum

DEPARTMENT: Board of Medical Examiners

TO : Continuing Medical Education Committee
Jack Breviu, Special Assistant Attorney General
James Cain, M.D., CME Committee Consultant

DATE: November 3, 1982

FROM : Jack Wallace JW
Assistant Executive Secretary

PHONE: (612) 623-5534

SUBJECT: Fee for the Emeritus Registration

The following is a list of the expenses that I anticipate for the emeritus registration for retired physicians. I am basing the costs on the estimate that we will have 250 physicians apply for this registration (since only the first item is fixed, an error in my estimate of numbers shouldn't make any difference):

Cost Items:	Cost:
Registration card and Certificate (cost of paper, reproducing designs)	$ 25.00 *
Clerical personnel, figured at 62.5 hours or fifteen minutes per applicant for a Clerk Typist II at the upper range of the pay scale. (consists of checking applicant's file for disciplinary action, typing wallet card, making Kroy lettering for certificates, xeroxing certificate, mailing out wallet cards and certificates, and any filing)	430.00
Staff personnel, figured at 12½ hours or three minutes per application for a Health Program Representative at the upper range of the pay scale. (would consist of dealing with any special problems related to the processing of applicants registrations)	128.00
	$583.00
	divided by 250 physicians
	$ 2.33 per registration ($. 2.71 counting postage)

* Cost was estimated by Brenda Braun a graphic artist for Information Services, Department of Health who is currently designing the wallet card and certificate. (A draft of the wallet cards and certificate should be ready for Committee approval for the March or May meeting).

continued

One point that I think was not made clear at the last CHE Committee meeting was that in order to obtain approval for a license fee it must be shown that receipts will cover anticipated costs. This concept of reasonableness is not a factor in obtaining approval for a licensure or registration fee.

Because of the low cost of this registration, I cannot make a staff recommendation any greater than five dollars. However, looking at the 1983 budget of current expenditures we have an estimated surplus of $5,583 without the emeritus registration fees, $6,833 if we charge five dollars, and $8,083 if we charge ten dollars. Because this is not as great a safety margin as in previous years, we could argue a greater fee as a way of balancing our overall costs. However, remember that this would help our overall budget for only one year, after the first year, I would doubt that we would ever have more than twenty emeritus registration requests per year.

However, my staff recommendation would still be to set the licensure fee at five dollars. Enclosed is a stamped, addressed envelope for your vote in regards to this matter or if we should have a conference phone call. I would like to get this done as soon as possible as the fee must have Board approval before the Department of Finance approval may proceed.

cc: David Carlson
Brenda Braun
Harold Broman, M.D.
Chester Anderson, M.D.
Wayne S. Burggraff
Terry Rogstad
Arthur Poore

SF-00005-02

STATE OF MINNESOTA

Office Memorandum

DEPARTMENT: Board of Medical Examiners

TO: Board of Medical Examiners

DATE: November 17, 1982

FROM: Jack Wallace JW
Assistant Executive Secretary

PHONE: (612) 623-5534

SUBJECT: Fee for the Emeritus Registration

Before the rules may be promulgated for CME and the emeritus registration, the Board must approve the registration fee for the emeritus registration. Before the Department of Finance will approve the emeritus registration fee, the Board of Medical Examiners must approve the fee.

Enclosed is a memo which was sent to the CME Committee which explains the rationale for setting the registration fee at five dollars. The proposal of the five dollar fee has been approved by three of the four members of the Committee, I have not heard from the fourth. In that I don't wish to delay this matter and would like to obtain the approval for the fee by the January Board meeting (and since I had a majority of the Committee vote), I decided to refer this to a Board vote.

Enclosed is a stamped envelope addressed to the Board, please let me know as soon as possible if the five dollar fee is okay, not okay or if the matter should be delayed for a full-board discussion (either at the next Board meeting or a telephone conference call). Those who have already approved the emeritus registration fee need not respond unless they have changed their minds.

cc: David Carlson
Val Vikmanis
Terry Rogstad
Jack Breviu
Arthur Poore

SUMMARY OF CME COMMITTEE
AND BOARD VOTE

CME COMMITTEE:

3 Yes 0 No 1 Abstintion

Board of Medical Examiners:

9 Yes 0 No 2 Abstintion

FALLS CLINIC PROFESSIONAL ASSOCIATION
P. O. Box 407
120 LaBree Avenue South
THIEF RIVER FALLS, MINNESOTA 56701
(218) 681-4747

November 11, 1982

To: Jack Wallace
Assistant Executive Secretary
Minnesota Board of Medical Examiners

From: G. B. Martin, M. D.

Subject: Advertising rules and fee for emeritus physician registration

I agree that the fee for emeritus physician registration should be set at $5.00. The memorandum regarding the advertising rules did not include a copy of those rules and I would request a copy since it would appear that this is the appropriate time for any other members of the board to share their feelings with the Advertising Committee.

I feel your point about not being destructively critical of the to refer this to a Board vote.

Enclosed is a stamped envelope addressed to the Board, please let me know as soon as possible if the five dollar fee is okay, not okay or if the matter should be delayed for a full-board discussion (either at the next Board meeting or a telephone conference call). Those who have already approved the emeritus registration fee need not respond unless they have changed their minds.

cc: David Carlson
Val Vikmanis
Terry Rogstad
Jack Breviu
Arthur Poore

OK
Tom Nelson MD

or fifteen minutes per applicant for a Clerk Typist at the upper range of the pay scale. (consists of checking applicant's file for disciplinary action, typing wallet card, making Kroy lettering for certificates, xeroxing certificate, mailing out wallet cards and certificates, and any filing)

Staff personnel, figured at 12½ hours or three minutes per application for a Health Program Representative at the upper range of the pay scale. (would consist of dealing with any special problems related to the processing of applicants registrations) 128.00

$5.00 is OK

$583.00

divided by 250 physicians

$ 2.33 per registration
($. 2.71 counting postage)

* Cost was estimated by Brenda Braun a graphic artist for Information Services, Department of Health who is currently designing the wallet card and certificate. (A draft of the wallet cards and certificate should be ready for Committee approval for the March or May meeting).

continued

Board meeting (and since I had a majority of the Committee vote), I decided to refer this to a Board vote.

Enclosed is a stamped envelope addressed to the Board, please let me know as soon as possible if the five dollar fee is okay, not okay or if the matter should be delayed for a full-board discussion (either at the next Board meeting or a telephone conference call). Those who have already approved the emeritus registration fee need not respond unless they have changed their minds.

cc: David Carlson
Val Vikmanis
Terry Rogstad
Jack Breviu
Arthur Poore

Approve - Dorothy Bowden, M.D.

Mayo Clinic

Rochester, Minnesota 55905 Telephone 507 284-2511

November 23, 1982

Richard B. Tompkins, M.D.
Department of Internal Medicine
Division of Rheumatology

Mr. Jack Wallace
Minnesota State Board of Medical Examiners
Suite 352
717 Delaware Street SE
Minneapolis, MN 55414

Dear Jack:

I think the $5 fee for emeritus registration is entirely appropriate and I think you should pursue it with the Department of Finance.

Sincerely yours,

Richard B. Tompkins, M.D.

RBT/dr

Chester Anderson, M.D.
Wayne S. Burggraff
Terry Rogstad
Arthur Poore

Jack,
I am in favor of the $5 fee.

Enclosed is a stamped envelope addressed to the Board, please let me know as soon as possible if the five dollar fee is okay, not okay or if the matter should be delayed for a full-board discussion (either at the next Board meeting or a telephone conference call). Those who have already approved the emeritus registration fee need not respond unless they have changed their minds.

cc: David Carlson
Val Vikmanis
Terry Rogstad
Jack Breviu
Arthur Poore

OK for S

David Thomas

Board meeting (and since I had a majority of the Committee vote), I decided to refer this to a Board vote.

Enclosed is a stamped envelope addressed to the Board, please let me know as soon as possible if the five dollar fee is okay, not okay or if the matter should be delayed for a full-board discussion (either at the next Board meeting or a telephone conference call). Those who have already approved the emeritus registration fee need not respond unless they have changed their minds.

cc: David Carlson
Val Vikmanis
Terry Rogstad
Jack Breviu
Arthur Poore

4/5 ok

DM

Enclosed is a stamped envelope addressed to the Board, please let me know as soon as possible if the five dollar fee is okay, not okay or if the matter should be delayed for a full-board discussion (either at the next Board meeting or a telephone conference call). Those who have already approved the emeritus registration fee need not respond unless they have changed their minds.

cc: David Carlson
Val Vikmanis
Terry Rogstad
Jack Breviu
Arthur Poore

If we are with the
$5 fee let's leave
A Board wants to go
If so that is fine also
Terry Olson
Ed Mendia

to refer this to a Board vote.

Enclosed is a stamped envelope addressed to the Board, please let me know as soon as possible if the five dollar fee is okay, not okay or if the matter should be delayed for a full-board discussion (either at the next Board meeting or a telephone conference call). Those who have already approved the emeritus registration fee need not respond unless they have changed their minds.

cc: David Carlson
Val Vikmanis
Terry Rogstad
Jack Breviu
Arthur Poore

SF-00003-02

STATE OF MINNESOTA

Office Memorandum

DEPARTMENT: BOARD OF MEDICAL EXAMINERS

TO : Dave Carlson
Section of Accounts and Finance

DATE: November 23, 1982

FROM : Jack Wallace JW
Assistant Executive Secretary

PHONE: 623-5534

SUBJECT: Approval of the Emeritus Registration Fee for retired physicians

Enclosed are the documents necessary in order to obtain the approval of the registration fee at $5.00. The $5.00 fee has been approved by seven of the eleven Board members. I am still awaiting a response from the other four. However, since seven does constitute a quorum and a majority, I am proceeding. Please contact me if anything further is necessary.

cc: Board of Medical Examiners
Jack Breviu
Arthur Poore
James Cain, M.D.
Val Vikmanis
Terry Rogstad

SF-00008-02

STATE OF MINNESOTA

Office Memorandum

DEPARTMENT: BOARD OF MEDICAL EXAMINERS

TO : Allen Yozamp, Director
Budget Planning and Control

DATE: November 23, 1982

FROM : Jack Wallace
Assistant Executive Secretary

PHONE: 623-5534

SUBJECT: Board of Medical Examiners fee for the Emeritus Registration

Listed below is the fee approved for the emeritus registration adopted by the Board of Medical Examiners through a mail vote. The vote was initiated in response to a memo dated November 17. The fees are in accordance with Minnesota Statutes Sections 16 A. 128 and 214.06. in status and will not be subject to renewal fees.

The total amount of revenue anticipated to be generated by the emeritus registration, when combined with the total amount of revenue anticipated to be generated from other fees charged by the Board approximates the amount appropriated plus the portion of the general support costs and statewide indirect costs of the agency.

	FY 83
Emeritus Registration	$5.00

Approved:

_____ _____

Allen Yozamp
Director
Budget Planning and Control Division

Date

BOARD OF MEDICAL EXAMINERS

Proposed Fees to Cover F.Y. 83 Anticipated Expenditures

Source

Type of Service	Quantity	Proposed Fee	Proposed Income
Physician Annual Registrations	13,340	$20.00	266,800.00
Examination/Endorsement Application Fees	100/154	125.00/ 100.00	66,900.00
Temporary Graduate Training Permits	9	15.00	135.00
Certification to Other States	160	10.00	1,600.00
Temporary Licenses	210	40.00	8,400.00
Osteopathic Annual Registrations	15	20.00	300.00
Physical Therapy Annual Registrations	1,932	5.00	9,660.00
Physical Therapy App/Endors	100/70	70.00/15.00	8,050.00
Corp. Renewals/New Registration	712/100	25.00/100.00	27,800.00
Emeritus Physician Registration	250	5.00	1,250.00
			390,895.00

F.Y. 83 Appropriations	376,032.00
Anticipated Indirect Cost for Statewide Services	5,654.00
Anticipated Minnesota Department of Health General Support Costs	3,401.00
Total Anticipated Costs	385,087.00
F.Y. 83	5,808.00

SF-00001-02

STATE OF MINNESOTA

DEPARTMENT of Finance

Office Memorandum

TO : Jack Wallace, Assistant Executive Secretary
Board of Medical Examiners

DATE: December 22, 1982

FROM : Allen A. Yozamp
Assistant State Budget Director

PHONE: 296-5188

SUBJECT: Physician Emeritus Fee Request

The purpose of this memorandum is to respond to your request for approval of a $5.00 fee for physician emeritus registration.

We are unable to approve the fee at this time unless your agency indicates it plans to hold a public hearing regarding the fee. This decision is based on our interpretation of M.S. 16A.128 as amended by the 1981 third special session of the legislature. The last sentence of this statute now reads; "Fee adjustments authorized under this section may be made without a public hearing when the total fees estimated to be received during the fiscal biennium will not exceed the sum of all direct appropriations, indirect costs, transfers in, and salary supplements for that purpose for the biennium."

The following is the actual/anticipated receipts and costs for the Medical Examiners Board for the current biennium. The information was taken from your most recently submitted fee review.

	F.Y. 82	F.Y. 83
Receipts	$408.0	$390.6
Receipts - Emeritus Registration		2.3
Total Receipts	$408.0	$392.9
Costs	361.3	385.2
Difference	$ 46.7	$ 7.7

The total receipts estimated for the biennium exceed the estimated biennial cost before the addition of the new fee. By our interpretation; any fee adjustment that does not bring the difference between estimated receipts and costs for the biennium to a negative amount will require a public hearing. The fact that revenue approximates costs is no longer relevant when determining if a public hearing must be held.

We also will be requiring additional information for future rate change requests. At a hearing with the Legislative Commission to Review Administrative Rules, it was felt we should review the reasonableness of individual

fees along with groups of fees. This is a valid concern and we will require that requests include the approximation of cost of processing each individual fee charged. For example; the Physician annual registration could be shown as follows:

1 hour clerical at $8.00 per hour	=	$8.00
1/2 hour professional at $12 per hour	=	6.00
Overhead, Supply & Expense	=	2.00
		$16.00

If you wish to discuss our interpretation of M.S. 16A.128 or the fee change procedures please contact me or Richard Hoeft (296-5155).

AY/R.H./pm
cc: Tom Rice

SF-0000340?

F

STATE OF MINNESOTA

DEPARTMENT BOARD OF MEDICAL EXAMINERS

Office Memorandum

TO : Allen A. Yozamp
Assistant State Budget Director

DATE: February 15, 1983

FROM : Jack Wallace JW
Assistant Executive Secretary

PHONE: 623-5534

SUBJECT: Physician Emeritus Fee Request

This is in response to your letter of December 22, 1982, in which your agency was unable to approve our request for $5.00 fee for the physician emeritus registration. The main problem concerned the fact that for fiscal year 1983, our estimated receipts exceed estimated costs. According to M.S.16A.128, when an agency's estimated fees exceed estimated costs, a public hearing must be held if that agency wishes to implement a new fee or adjust an existing fee.

The emeritus registration for physicians is a newly proposed status, and is covered in proposed rule which will have to go through a public hearing before it becomes law. Subsection E. of the proposed emeritus registration rule establishes the fee for the registration, "The fee for such a document shall be one-fourth of the annual licensure fee." (The current annual licensure fee being twenty dollars, we would be willing to change the rule to a flat five dollars.) Since the emeritus registration fee is covered in the rule, and since the rule will go to public hearing, will this satisfy the legal requirement of M.S.16A.128? We are willing to highlight the subsection and to specify that the Board is planning on setting the fee at five dollars on the notices of the public hearing, if necessary. As you know the hearing examiner will not schedule a hearing for the rule unless all fees have been approved by your department. A copy of the proposed rule is enclosed (page 5).

Also in your memo you requested an approximate breakdown on the cost of processing an individual emeritus registration. The breakdown is as follows:

COST ITEM	COST
Registration card and Certificate (cost of paper, reproducing designs)	$ .10
Clerical personnel for the processing of initial registration, figured at fifteen minutes per applicant for a Clerk Typist II at the upper range of the pay scale. (consists of checking applicant's file for disciplinary action, typing wallet card, making Kroy lettering for certificates, xeroxing certificate, mailing out wallet cards anc certificates, and any filing)	1.72

Staff personnel for the processing of initial registration, figured at three minutes per application for a Health Program Representative at the upper range of the pay scale. (would consist of dealing with any special problems related to the processing of applicants registrations)	.51
Postage and envelope for certificate	.47
Allowances for additional processing after licensure, figured at two minutes of clerical time and two minutes of staff time. (would consist of receiving and processing of any complaints and forward the complaints to the Board of Pharmacy and the Attorney General when applicable)	.56
	3.36

Please contact me in regards to this matter, should you have any questions, please contact our office.

cc: CME Committee
Chester Anderson, M.D.
James Cain, M.D.
Arthur Poore
Terry Rogstad
Dave Carlson
Tom Rice
Richard Hoeft

SF-00006-02

DEPARTMENT

STATE OF MINNESOTA

Office Memorandum

TO : Jack Wallace, Assistant Executive Secretary
Board of Medical Examiners

DATE: March 3, 1983

FROM : Allen A. Yozamp
Assistant State Budget Director

PHONE: 296-5188

SUBJECT: Physician Emeritus Fee Request

The purpose of this memorandum is to inform you that your request of a $5.00 fee for physician emeritus registration is approved.

Since your board indicates it intends to hold a public hearing the requirements of M.S. 16A. 128 will be met.

If you wish to discuss this fee approval or the fee procedures please contact me or Richard Hoeft (296-5155).

AY:RH/pa

H

The Minnesota State Board of Medical Examiners

EXECUTIVE OFFICE
Suite 332
717 Delaware Street S.E.
Minneapolis, Minnesota 55414
(612) 296-5330

November 4, 1982

Dean D. Nywall, M.D.
2744 Broadway Avenue
Dayton, Minnesota 56172

Dear Doctor Nywall:

The Board of Medical Examiners is presently attempting to promulgate rules which will establish an "emeritus registration" for those physicians who are retired. The rules have been drafted, I am currently finishing up a Statement of Need and Reasonableness for the new rule. The Statement of Need and Reasonableness is a very long and tedious document which establishes the fairness and need for a new rule. As part of my arguement for the new rule I was wondering if I could use your letter of October 2, 1981, addressed to the Board. I feel that your letter was an excellent summarization of the feelings of many retired doctors suddenly faced with a new requirement in order to keep their medical license, a requirement which they didn't have to meet when they were practicing.

The quote I wish to use is as follows: "it took 20 years, from high school till I finished my internship, to acquire my M.D., and I have practiced for 30 years... You have rules I know, but as I've stated, I have no intentions, for reasons of future health, of ever practicing medicine again. I would just like to continue to feel that I am a doctor of medicine."

Please let me know if it is okay for me to use this quote. Enclosed is a copy of the latest draft of the rules for your review, I can send you a copy of the Statement of Need and Reasonableness when it is completed.

Sincerely yours,

Jack Wallace

JACK WALLACE
Assistant Executive Secretary

You certainly may use the quote!
DDN

JW/bd

cc: Jack Breviu
Sam Grais
James Cain, M.D.
Arthur Poore