

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

Our File No. 1021

RULE REVIEW CHECKLIST

DATE RULE RECEIVED 4-16-84
DATE FOR REVIEW 4-25-84
DATE DUE 4-30-84

Adopted w/a hearing _____
Adopted w/o hearing ✓
Temporary rule _____

Approved 4-30-84 Disapproved _____ Returned to Agency _____

Resubmitted _____ Due _____
Approved _____ Disapproved _____ Returned to Agency _____

Date filed w/Secretary of State _____ Revisor approved 4.17.84
disapproved _____

✓ Rule as Adopted

✓ Rule as Proposed See SR

✓ Order Adopting 4.12.84 Date

✓ Notice of Intent to Solicit Outside Opinion SR. 5.2.83

_____ Order for rulemaking
_____ date of Hearing not submitted

_____ Certificate of Board's Authorizing Resolution not submitted.

✓ Notice of rulemaking
✓ Sufficiency notice as mailed is identical to notice in SR.

✓ Affidavit of Mailing Notice or rulemaking
12.28.30.83 At least 30 days prior to ~~hearing~~/adoption

✓ Mailing list Certificate

✓ Publication in State Register
12.26.83 At least 30/~~20~~ days prior to ~~hearing~~/adoption

N/A Hearing Examiner's Report

_____ Chief Hearing Examiner's Report(s)
_____ Approving H.E.'s Report
_____ Approving agency action

✓ Agency's Findings of Fact

N/A LCRAR Report or agency Affidavit

✓ Certificate of Board's Resolution Adopting Rules

N/A Order Approving Incorporation by Reference

✓ Statement of Need and Reasonableness

N/A Petition for Adoption of a Rule

✓ Record (includes transcript or tape, exhibits, comments received by agency, requests for a hearing, and other relevant materials)

✓ Certificate of Compliance w/Rulemaking Procedures

✓ Affidavit of Mailing Notice of Submission to Attorney General

N/A Notice of Submission to the Attorney General

SF-00006-03

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL - Health

Office Memorandum

TO: Judith Wehrwein
Administration
Attorney General

DATE: April 16, 1984

FROM: John A. Breviu
Special Assistant
Attorney General

PHONE: 341-7272

SUBJECT: In the Matter of the Proposed Rule Regarding Changes in the Continuing Medical Education Reqirement Necessary for Physicians and Osteopaths to Retain their Licenses to Practice Medicine

Pursuant to 1 MCAR § 1.203, please find enclosed for your review and approval:

1. Rule as adopted (original and three copies);
2. Order Adopting Rule (original and one copy);
3. Certificate of Board's Resolution;
4. Notice of Intent to Solicit Outside Opinion;
5. Certificate of Board's Authorizing Resolution;
6. Notice of Intent to adopt a Rule Without Public Hearing;
7. Affidavit of Mailing;
8. Mailing List Certificate;
9. Rule as Proposed;
10. Statement of Need and Reasonableness;
11. Written comments;
12. Certificate of Compliance with Rulemaking Procedures;
13. Affidavit.

If you have any questions, please feel free to call me.

JAB:jrm

Attachments

SF-00006-02

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL

Office Memorandum

TO Arthur W. Poore
Executive Secretary

DATE: April 30, 1984

ATTN: John A. Breviu, Special Asst.,
FROM : Attorney General

PHONE: 297-3493

Larry D. Starns
Special Assistant LDS
Attorney General

SUBJECT:

In the Matter of the Proposed Rule Regarding Changes in the Continuing Medical Education Requirement Necessary for Physicians and Osteopaths to Retain Their Licenses to Practice Medicine

Enclosed herewith are the rules you have submitted for approval. These rules have been approved by this office and filed with the Secretary of State. Please note that they have not been filed with the State Register. This must be done promptly by your agency.

Upon receipt and before transmittal to your agency, however, it is important that you recheck these rules as to:

1. Affixation of stamps of the Attorney General and Secretary of State;

2. Coverage by these stamps of all rules submitted; and

3. Inclusion of all pages to the rules in the approved set.

If you have any questions in this regard, please contact me.

Encs.

cc: Ms. Kathy Burek
Mr. Duane Harves

LDS:cb

AG copy

State Board of Medical Examiners

Adopted Rule Regarding Changes in the Continuing Medical Education Requirement Necessary for Physicians and Osteopaths to Retain Their Licenses to Practice Medicine

Rules as Adopted

7 MCAR S 4.012 Continuing medical education.

A. Continuing education cycles. During three-year cycles, each physician licensed to practice by this board shall obtain 75 hours of continuing medical education credit as required by this rule.

For the purpose of administering this rule, 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 and the January 1 following the date of initial licensure may be credited towards the first cycle.

Those individuals assigned three-year reporting prior to the effective date of this rule shall remain in their assigned reporting cycle.

B. Activities for which credit may be obtained. Continuing medical education credit may be obtained from the following activities:

1. Category 1. No less than 45 hours of credit must be obtained in any cycle by attendance at educational activities approved by the board pursuant to D.

2. Category 2. No more than 20 hours of credit may be obtained in any cycle through educational activities sponsored by a hospital, clinic, or medical or osteopathic society and not meeting the standards contained in category 1.

3. Category 3. No more than 20 hours of credit may be obtained in any cycle through medical teaching of medical students, residents, practicing physicians, and allied health

professionals.

4. Category 4. No more than 20 hours of credit may be obtained in any cycle for papers, publications, books, lectures, and exhibits.

a.-c. [Unchanged.]

5. Category 5. No more than 20 hours of credit may be obtained by engaging in professional reading, peer patient care review activities, self-assessment examinations sponsored by a professional organization recognized by the board as maintaining a significant level of quality control, and preparation for certification or recertification examinations administered by a national specialty board.

C. Approval of courses for credit. Persons or organizations intending to offer courses for continuing education credit not included under D.6. may apply to the board in advance for approval. Any person or organization may submit a course for approval by the board. The following information shall be provided to the board, as well as any other information which the board may reasonably require for the purpose of evaluating the course for which approval is sought.

1.-4. [Unchanged.]

D. Category 1 credit. The board shall grant Category 1 continuing education credit for any educational activity which meets the following standards:

1.-5. [Unchanged.]

6. Any course planned, sponsored, or co-sponsored by a medical or osteopathic medical school, state or national medical or osteopathic association, or a national medical specialty society shall be presumed to meet the above standards. This presumption may be withdrawn by the board if it determines that a school, association, or specialty society has sought credit for a course not meeting these standards.

E. [Unchanged.]

F. Alternative compliance. The board may accept certification or recertification by an American specialty board in lieu of compliance with the continuing education requirements

ok — w/in reasonable discretion qbd & stat'g auth. — LDS

during the cycle in which certification or recertification is granted.

G. Verification of compliance. Licensees shall, at the relicensure period coinciding with the end of their cycle, provide a signed statement to the board on a form provided by the board indicating compliance with this rule. The board may, in its discretion, require such additional evidence as is necessary to verify compliance with the rule. 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.

A licensee failing to submit a statement or who submits a statement which, on its face, indicates noncompliance with this rule may be subject to the disciplinary provisions contained in I.

H. Exemptions.

1. The board may grant an exemption from the continuing education requirements of this rule to a licensee for full-time participation in residency or fellowship training at a professionally accredited institution.

2. Physicians under emeritus registration status as provided in 7 MCAR S 4.013 are exempt from the continuing medical education requirements of this rule.

I. Penalties for noncompliance. The board may refuse to renew, suspend, condition, limit, or qualify the license of any person whom the board determines has failed to comply with the requirements of this rule.

If the board refuses to renew a license, a hearing must be held only if the licensee submits a written request for a hearing within 30 days after receiving notice of the refusal to renew. The hearing must be conducted pursuant to the provisions of the Minnesota Administrative Procedure Act.

7 MCAR S 4.0121 Emeritus registration for retired physicians.

A. Application. Any physician duly licensed to practice medicine in the state pursuant to Minnesota Statutes, chapter

147, 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.

B. Status of registrant. The emeritus registration is not a license to engage in the practice of medicine as defined in Minnesota Statutes, chapter 147, or in the rules of the board. The registrant shall not engage in the practice of medicine.

C. Continuing education requirements not applicable. The continuing medical education requirements of 7 MCAR S 4.012 are not applicable to emeritus registration.

D. Change to active status. 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:

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;

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 S 4.012 A. This requirement must be fulfilled prior to submission of the application;

3. submission of all back licensure fees while one's license was under inactive status and the emeritus registration;

4. submission of references by two physicians licensed to practice medicine in Minnesota verifying that the registrant has the capacity to practice medicine; and

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.

E. Documentation of status. A physician granted emeritus 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 $5. The document fee shall not be a prerequisite for consideration of an application for emeritus registration.

F. Renewal cycle or fees not applicable. Being registered as emeritus will not subject a person to the annual renewal cycle or renewal fees.

APPROVED AS TO LEGALITY

April 30, 1984

HUBERT H. HUMPHREY, III
ATTORNEY GENERAL

BY _____
SPECIAL ASSISTANT ATTORNEY GENERAL

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
APR 30 1984
4:16 P.M

_____
Secretary of State

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

BOARD OF MEDICAL EXAMINERS

In the Matter of the Proposed Rule Regarding Changes in the Continuing Medical Education Requirement Necessary for Physicians and Osteopaths to Retain Their Licenses to Practice Medicine

ORDER ADOPTING RULE

Notice of the Minnesota Board of Medical Examiner's intent to adopt the above-entitled rule without a public hearing was published in the State Register on December 26, 1983, and was sent by United States mail to all persons on the list maintained by the Minnesota Board of Medical Examiners pursuant to Minn. Stat. § 14.14, subd. 1a (Supp. 1983), on December 23, 1983. After affording interested and affected persons an opportunity to submit comments for 30 days after Notice, receiving no requests for a public hearing within the 30-day comment period, and determining the need for the reasonableness of the above-captioned rules,

NOW, THEREFORE, IT IS ORDERED that the rule identified as Rule Regarding Changes in the Continuing Medical Education Requirement Necessary for Physicians and Osteopaths to Retain Their Licenses to Practice Medicine is adopted this 12th day of April, 1984, pursuant to authority vested in me by Minn. Stat. § 147.02 (1982) and by resolution of the Minnesota Board of Medical Examiners duly adopted at a meeting of the said Board on the 10th day of March, 1984.

STATE OF MINNESOTA

BOARD OF MEDICAL EXAMINERS

Arthur W. Poore

ARTHUR W. POORE
Executive Secretary

Arthur W. Poore, Executive Secretary
Minnesota Board of Medical Examiners
717 S.E. Delaware Street, Suite 352
Minneapolis, Minnesota 55414

All statements of information and comments must be received by July 1, 1983.

Arthur W. Poore
Executive Secretary

Notice of Intent to Solicit Outside Opinion Concerning a Proposed Rule Regarding the Practice of Physical Therapy

Notice is hereby given that the Minnesota Board of Medical Examiners is considering the adoption of a rule for the regulation of the practice of physical therapy which will modify the information required on the application form, change the requirements for registration without examination, establish registration requirements for foreign-trained applicants, establishes the legal supervisory and delegatory relationship of the physical therapist with the physical therapist assistant and the physical therapy aide, establishes the Professional Examination Service examination for physical therapists or comparable tests as the examinations for registration, changes in the requirements for the physical therapist to retain records of prescriptions, elimination of the time limits placed upon prescriptions for physical therapists and the establishment of appointment guidelines for the Physical Therapy Council.

This proposed rule is authorized by Minnesota Statute § 148.70, which established authority for the Board of Medical Examiners with the advice and assistance of the Physical Therapy Council to regulate the practice of physical therapy in the interest and protection of the public.

All interested or affected persons or groups may submit information on this subject. The rule may be revised on the basis of comments received. Any written material received will become part of the record of any rule hearings held on this subject. Written or oral information and comments should be addressed to:

Arthur W. Poore, Executive Secretary
Minnesota Board of Medical Examiners
717 S.E. Delaware Street, Suite 352
Minneapolis, Minnesota 55414

All statements of information and comments must be received by July 1, 1983.

Arthur W. Poore
Executive Secretary

✓ Notice of Intent to Solicit Outside Opinion Concerning a Proposed Rule Regarding Changes in the Continuing Medical Education Requirements Necessary for Physicians and Osteopaths to Retain their Licenses to Practice Medicine

Notice is hereby given that the Minnesota Board of Medical Examiners is considering the adoption of a rule which will lower the overall continuing medical education requirement, necessary for relicensure, from 150 hours to 75 hours, modify the maximum and/or minimum level of the five CME categories for which the physician or osteopath may obtain credit, and exempt those physicians or osteopaths under the emeritus registration from the CME requirement.

This proposed rule is authorized by Minnesota Statute § 214.12, which establishes the authority for health manpower regulatory authorities to implement Continuing Medical Education requirements as a means of improving the professional skills of the licensees or registrants on an ongoing basis.

All interested or affected persons or groups may submit information on this subject. The rule may be revised on the basis of comments received. Any written material received will become part of the record of any rule hearings held on this subject. Written or oral information and comments should be addressed to:

Arthur W. Poore, Executive Secretary
Minnesota Board of Medical Examiners
717 S.E. Delaware Street, Suite 352
Minneapolis, Minnesota 55414

All statements of information and comments must be received by July 1, 1983.

Arthur W. Poore
Executive Secretary

provided by the authority a final project status report and a financial status report that gives actual expenditures of the measures implemented.

D. Annual energy report. The school district shall submit to the authority on forms provided by the authority an annual energy use and energy expenditure report by fuel type due each October 31 for the duration of the loan contract period, or for a minimum of three years after project completion if the loan is prepaid in less than three years, unless the authority cancels this requirement statewide prior to the end of the loan contract period.

6 MCAR § 2.2508 [Temporary] Program evaluation.

The authority shall design and implement by rule an evaluation of the loan program. Loan recipients shall agree to provide to the authority in a timely manner the information that is reasonably needed to evaluate the loan program.

6 MCAR § 2.2509 [Temporary] Closure of loan account.

If the authority determines that the project that was approved for loan funds has been implemented, it shall authorize closure of the loan account upon full repayment.

State Board of Medical Examiners

Proposed Rule Regarding Changes in the Continuing Medical Education Requirement Necessary for Physicians and Osteopaths to Retain Their Licenses to Practice Medicine

Notice of Intent to Adopt Rules without a Public Hearing

Notice is hereby given that the Minnesota Board of Medical Examiners proposes to adopt the above entitled rules without a public hearing. The Board has determined that the proposed adoption of these rules will be noncontroversial in nature and has elected to follow the procedures set forth in Minnesota Statutes sections 14.21-14.28 (1982).

Minnesota Statutes section 214.12 establishes the authority for health manpower regulatory authorities to implement Continuing Education requirements as a means of improving the professional skills of the licensees or registrants on an ongoing basis. The Board has promulgated continuing medical education rules which fulfill the intent of section 214.12. However, through the administration of the existing continuing medical education rules the Board, with the assistance of a continuing medical education sub-committee, developed these revisions to the rules based upon the Board's experience with the rules. Additionally, a statement of need and reasonableness that describes the need and reasonableness of the proposed rules has been prepared and is available for inspection by the public during regular business hours or may be provided upon request, at the address below.

Persons interested shall have 30 days, specifically until January 25, 1984, to submit comments on the proposed rules. The proposed rules may be modified if the modifications are supported by the data and views submitted to the agency and do not result in a substantial change in the proposed language.

Upon adoption of the final rule without a public hearing, the proposed rule, this notice, the statement of need and reasonableness, all written comments received, and the final rule as adopted will be delivered to the Attorney General for review as to form and legality, including the issue of substantial change. Persons who wish to be advised of the submission of this material to the Attorney Geneal, or who wish to receive a copy of the final rule as proposed for adoption, should submit a written request to the below address.

Unless seven (7) or more persons submit written requests for a public hearing on the proposed rules within the 30-day comment period, a public hearing will not be held. In the event a public hearing is required, the agency will proceed according to the provisions of Minnesota Statutes 14.13-14.20 (1982). The agency asks that persons requesting a public hearing identify the particular provisions objected to, the suggested modifications to the proposed rules, and the reasons or data relied on to support the suggested modifications.

Please be advised that Minn. Stat. chapter 10A requires each lobbyist to register with the State Ethical Practices Board within five days after he or she commences lobbying. Minn. Stat. § 10A.01. subdivision 11 defines a lobbyist as an individual:

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

(a) engaged for pay or other consideration or authorized by another individual or association to spend money, who spends more than five hours in any month or more than $250, not including his own travel expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials; or (b) who spends more than $250, not including his own travel expenses and membership dues in any year, for the purpose of attempting to influence legislative administrative action by communicating or urging others to communicate with public officials. The statute provides certain exceptions. Questions should be directed to the Ethical Practice Board, 41 State Office Building, St. Paul, Minnesota 55155, telephone (612) 296-5615.

A copy of the proposed rule follows this notice. Additional copies may be obtained at the address below.

Persons who wish to submit comments or a written request for a public hearing, or who wish to receive a copy of the final rule or to be informed when the rule is submitted to the Attorney General, should submit such comments to:

Arthur W. Poore, Executive Secretary
Minnesota Board of Medical Examiners
717 Delaware Street SE, Suite #352
Minneapolis, MN 55414

Rules as Proposed

7 MCAR § 4.012 Continuing medical education.

A. Continuing education cycles. During three-year cycles, each physician licensed to practice by this board shall obtain ~~150~~ 75 hours of continuing medical education credit as required by this rule.

~~1.~~ For the purpose of administering this rule, ~~the board will establish three classes of licensees as follows:~~ 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 and the January 1 following the date of initial licensure may be credited towards the first cycle.

Those individuals assigned three-year reporting prior to the effective date of this rule shall remain in their assigned reporting cycle.

~~a. Class I. Licensees in this class will be required to complete 50 hours of continuing education by December 31, 1978. These hours shall include at least 20 hours of Category 1 credit. However, no more than 15 hours of credit may be obtained in any one of the other categories. Thereafter, the licensees in this class shall report to the board at three year intervals.~~

~~b. Class II. Licensees in this class will be required to complete 100 hours of continuing education by December 31, 1979. These hours shall include at least 40 hours of Category 1 credit. However, no more than 30 hours of credit may be obtained in any one of the other categories. Thereafter, the licensees in this class shall report to the board at three year intervals.~~

~~c. Class III. Licensees in this class shall be required to complete 150 hours of continuing education by December 31, 1980. These hours shall be obtained in such a way as to fully comply with the requirements of 7 MCAR § 4.012 B. Thereafter, the licensees in this class shall continue to report to the board at three year intervals.~~

~~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.~~

~~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.~~

B. Activities for which credit may be obtained. Continuing medical education credit may be obtained from the following activities:

1. Category 1. No less than ~~60~~ 45 hours of credit ~~shall~~ must be obtained in any cycle by attendance at educational activities approved by the board pursuant to ~~7 MCAR § 4.012~~ D.

2. Category 2. No more than ~~45~~ 20 hours of credit may be obtained in any cycle through educational activities sponsored by a hospital, clinic, or medical or osteopathic society and not meeting the standards contained in category 1.

3. Category 3. No more than ~~45~~ 20 hours of credit may be obtained in any cycle through medical teaching of medical students, residents, practicing physicians, and allied health professionals.

4. Category 4. No more than ~~40~~ 20 hours of credit may be obtained in any cycle for papers, publications, books, lectures, and exhibits.

a.-c. [Unchanged.]

5. Category 5. No more than ~~45~~ 20 hours of credit may be obtained by engaging in professional reading, peer patient care review activities, self-assessment examinations sponsored by a professional organization recognized by the board as maintaining a significant level of quality control, and preparation for certification or recertification examinations administered by a national specialty board.

~~Approval of courses for credit.~~

C. Approval of courses for credit. Persons or organizations intending to offer courses for continuing education credit not included under ~~7 MCAR § 4.012~~ D.6. may apply to the board in advance for approval. Any person or organization may submit a course for approval by the board. The following information shall be provided to the board, as well as any other information which the board may reasonably require for the purpose of evaluating the course for which approval is sought.

1.-4. [Unchanged.]

D. Category 1 credit. The board shall grant Category 1 continuing education credit for any educational activity which meets the following standards:

1.-5. [Unchanged.]

6. Any course planned, sponsored, or co-sponsored by a medical or osteopathic medical school, state or national medical or osteopathic association, or a national medical specialty ~~board~~ society shall be presumed to meet the above standards. This presumption may be withdrawn by the board if it determines that a school, association, or specialty ~~board~~ society has sought credit for a course not meeting these standards.

E. [Unchanged.]

F. Alternative compliance. The board may accept certification or recertification by an American specialty board in lieu of compliance with the continuing education requirements during the cycle in which certification or recertification is granted. ~~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.~~

G. ~~Upon application, the board shall issue retroactive approval of any educational activity offered after January 1, 1977 which meets the standards for approval contained in this rule.~~

~~H.~~ Verification of compliance. Licensees shall, at the relicensure period coinciding with the end of their cycle, provide a signed statement to the board on a form provided by the board indicating compliance with this rule. The board may, in its discretion, require such additional evidence as is necessary to verify compliance with the rule. 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.

A licensee failing to submit a statement or who submits a statement which, on its face, indicates noncompliance with this rule may be subject to the disciplinary provisions contained in ~~7 MCAR § 4.012 J.~~ I.

~~I.~~ H. Exemptions.

1. The board may grant an exemption from ~~these~~ the continuing education requirements of this rule to a licensee for full-time participation in residency or fellowship training at a professionally accredited institution.

2. Physicians under emeritus registration status as provided in 7 MCAR § 4.013 are exempt from the continuing medical education requirements of this rule.

~~J.~~ I. Penalties for noncompliance. The board may refuse to renew, suspend, condition, limit, or qualify the license of any person whom the board determines has failed to comply with the requirements of this rule.

If the board refuses to renew a license, a hearing ~~shall~~ must be held only if the licensee submits a written request for a hearing within 30 days after receiving notice of the refusal to renew. ~~Any such~~ The hearing ~~shall~~ must be conducted pursuant to the provisions of the Minnesota Administrative Procedure Act.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

STATE OF MINNESOTA)
) ss.
COUNTY OF HENNEPIN)

In the Matter of the Proposed Rule Regarding Changes in the Continuing Medical Education Requirement Necessary for Physicians and Osteopaths to Retain Their Licenses to Practice Medicine

AFFIDAVIT OF MAILING

Barbara DeLong, being first duly sworn, deposes and says:

That between the 28th and 30th days of December, 1983, at the City of Minneapolis, County of Hennepin, State of Minnesota, she served the attached Notice of Intent to Adopt Rules Without a Public Hearing by depositing in the United States mail at said City of Minneapolis, a true and correct copy thereof, properly enveloped, with postage prepaid, to all persons and associations who have requested that their names be placed on file with the Minnesota Board of Medical Examiners for the purpose of receiving notice of the proposed adoption of rules by the Minnesota Board of Medical Examiners.

Barbara DeLong
BARBARA DeLONG

Subscribed and sworn to before me
this 12th day of April, 1984.

Alice D. Hummer

ALICE D. HUMMER
NOTARY PUBLIC-MINNESOTA
RAMSEY COUNTY
MY COMMISSION EXPIRES NOVEMBER 18, 1988

STATE OF MINNESOTA

COUNTY OF HENNEPIN

CERTIFICATE

In the Matter of the Proposed Rule
Regarding Changes in the Continuing
Medical Education Requirement Necessary
for Physicians and Osteopaths to Retain
Their Licenses to Practice Medicine

I hereby certify that the attached list of persons, associations, and other interested groups who have requested, pursuant to Minn. Stat. § 14.14 subd. 1a (Supp. 1983), that their names be placed on file with and maintained by the Minnesota Board of Medical Examiners for the purpose of receiving notice of the proposed adoption of rules by this Board is accurate and complete as of 4:30 PM, the 23rd day of December, 1983.

ARTHUR W. POORE
Executive Secretary

CITIZENS RECEIVING INFORMATION ON ALL THE RULES

Kathy Meyerle
Minnesota Medical Association
2221 University Avenue SE #400
Minneapolis, MN 55414

Lynn Gruber
Hennepin County Medical Society
2221 University Avenue SE #423
Minneapolis, MN 55414

Frundt, Frundt, & Johnson
Attorneys at Law
117 West 5th Street
Blue Earth, MN 56013

Broeker Hartfeldt Hedges & Grant
Attorneys at Law
2850 Metro Drive - Suite 800
Minneapolis, MN 55420

Dorsey Windhorst Hannaford Whitney
& Halladay
2300 First National Bank Bldg
Minneapolis, MN 55402

Minnesota State Pharmaceutical
Association
2469 University Avenue
St. Paul, MN 5511
Attn: Donald A. Dee, Exec. Dir.

Thomas M. Polt
Attorney at Law
McCarthy Bldg.
Eyota,MN 55934

Peterson Popovich Knutson & Flynn
Professional Association
314 Minnesota Bldg.
St. Paul, MN 55101

Minnesota Association of Health Care
Facilities
Attn: Rick Carter
2850 Metro Drive, Suite 429
Minneapolis, MN 55420

Minnesota Board of Optometry
Executive Secretary
717 Delaware Street SE
Minneapolis, MN 55414

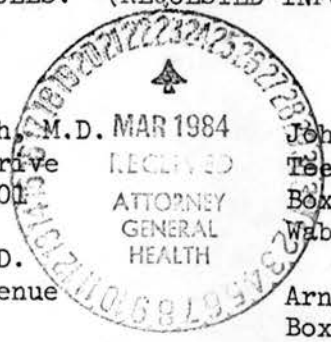
Minnesota Board on Aging
204 Metro Square Building
St. Paul, MN 55101

Board of Psychology
Executive Secretary
717 Delaware Street SE #343
Minneapolis, MN 55414

Department of Professional Regulation
Complaint Analysis Section
2009 Apalachee Parkway
Tallahassee, FL 32301

All other health licensing boards were sent notices, although the notices were not requested.

CITIZENS RECEIVING INFORMATION ON THE PROMULGATION ON THE CONTINUING MEDICAL EDUCATION AND PHYSICIAN EMERITUS REGISTRATION RULES. (REQUESTED INFORMATION ON THESE TWO RULES)



Gordon C. MacRae, M.D.
8100 Highwood Drive #Y317
Bloomington, MN 55438

Eugene Urbani, M.D.
1257 12th Avenue, North
St. Cloud, MN 56301

David Burlingame, M.D.
14587 30th Street, North
Stillwater, MN 55082

Robert A. Braun, M.D.
815 Kirts
Troy, MI 48084

Elma M. Howard, M.D.
Box 1276
Miles City, MT 59301

George Van Rooy, M.D.
Rt. #1
Thief River Falls, MN 56701

Stella Sikkema, M.D.
3941 40th Avenue, South
Minneapolis, MN 55406

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CERTIFICATE OF BOARD'S

ADOPTION OF RULES RESOLUTION

I, Arthur W. Poore, do hereby certify that I am the Executive Secretary of the Minnesota Board of Medical Examiners, a board duly authorized under the laws of the State of Minnesota, and that the following is a true, complete, and correct copy of the resolution adopted at a meeting of the said Board of Medical Examiners duly and properly called and held on the 10th day of March, 1984; that a quorum was presented at said meeting; that a majority of those present voted for the resolution; that said resolution is set forth in the minutes of said meeting and has not been rescinded or modified.

> "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."

IN WITNESS WHEREOF, I have hereunto subscribed my name this 12th, day of April, 1984.

STATE OF MINNESOTA

BOARD OF MEDICAL EXAMINERS

Arthur W. Poore

ARTHUR W. POORE
Executive Secretary

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

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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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STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

BOARD OF MEDICAL EXAMINERS

In the Matter of the Proposed Rule Regarding Changes in the Continuing Medical Education Requirement Necessary for Physicians and Osteopaths to Retain Their Licenses to Practice Medicine

CERTIFICATE OF COMPLIANCE WITH RULEMAKING PROCEDURES

I, Special Assistant Attorney General John A. Breviu, do hereby declare that I have examined the above-captioned and all related documents and that, based on my examination and my personal familiarity with the applicable procedures, the Administrative Procedure Act, the rules of the Office of Administrative Hearings, and the rules of the Attorney General have been followed without any exceptions.

Dated: April 16, 1984

John A. Breviu

JOHN A. BREVIU
Special Assistant
Attorney General

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

BOARD OF MEDICAL EXAMINERS

In the Matter of the Proposed Rule Regarding Changes in the Continuing Medical Education Requirement Necessary for Physicians and Osteopaths to Retain Their Licenses to Practice Medicine

AFFIDAVIT

STATE OF MINNESOTA)
) ss.
COUNTY OF HENNEPIN)

Arthur W. Poore, being first duly sworn upon oath, deposes and says:

1. That on December 26, 1983, a Notice of Intent to Adopt Rules Without a Public Hearing was published in the State Register and on December 28-30, 1983, the same Notice was mailed to persons who have requested to be informed of rulemaking activity by the Minnesota Board of Medical Examiners;

2. That to date, no one has requested a rule hearing nor has anyone requested to be informed of submission of the rule to the Attorney General's Office for review as to form and legality.

FURTHER AFFIANT SAYETH NOT.

Dated: April 12, 1984.

Arthur W. Poore

ARTHUR W. POORE
Executive Secretary

Subscribed and sworn to before me
this 12th day of April, 1984

Alice D. Hummer

ALICE D. HUMMER
NOTARY PUBLIC-MINNESOTA
RAMSEY COUNTY
MY COMMISSION EXPIRES NOVEMBER 18, 1988