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**BOARDS OF MEDICINE AND OSTEOPATHIC MEDICINE
PAIN MANAGEMENT CLINIC STANDARDS OF PRACTICE
JOINT COMMITTEE MEETING**

**November 21, 2009
10:01 a.m. -- 3:46 p.m.**

**Marriott Orlando Airport
7499 Augusta National Drive
Orlando, Florida**

**Reported By:
Cynthia R. Green, Court Reporter**

1 **PERSONS PRESENT:**

2 **FRED BEARISON, M.D., CHAIR**

3 **ALLAN ESCHER, M.D., VICE-CHAIR**

4 **ONELIA LAGE, M.D. (until 1:00)**

5 **STEVEN P. ROSENBERG, M.D.**

6 **ROBERT CLINE, M.D. (until 1:40)**

7 **ROBERT MCCANN, D.O.**

8 **JOHN BEEBE**

9 **KAYE HOWERTON, EXECUTIVE DIRECTOR**

10 **LARRY MCPHERSON, EXECUTIVE DIRECTOR**

11 **DONNA MCNULTY, ESQUIRE**

12 **ED TELLECHEA, ESQUIRE**

13 **NANCY MURPHY, PARALEGAL**

14 **CHRISTY ROBINSON, PROGRAM OPERATIONS ADMINISTRATOR**

15 **EULINDA SMITH, PUBLIC INFORMATION OFFICER**

16 **CYNTHIA R. GREEN, COURT REPORTER**

17 **ERNIE KIMBLE, AUDIO SPECIALIST**

18 **ALSO PRESENT:**

19 **ANA M. VIAMONTE ROS, STATE SURGEON GENERAL**

20 **VARIOUS AUDIENCE MEMBERS AND PUBLIC SPEAKERS**

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P R O C E E D I N G S

November 21, 2009

10:01 a.m.

(The Board of Medicine and Osteopathic
Medicine Pain Management Clinic Standards of
Practice Joint Committee Meeting was called to
order, after which the following took place, in
re: Training Requirements for Health Care
Practitioners Not Regulated by Another Board.)

CHAIRMAN BEARISON: Okay. Next I think
we're going to go ahead and go to the -- the
Training Requirements for Health Care
Practitioners Not Regulated by Another Board.

Before we go ahead and do that -- and when
I'm done, Mr. McPherson, if you'd like to add
anything, please go ahead. I'd just like to
recognize that all the Board members have
received the report from the Broward Grand Jury
and their recommendations, and I specifically at
this point in time would like to make mention to
the fact of page 47, which is a synopsis,
there's recommendations which the Grand Jury
made, number eight, number nine, number ten and
number eleven, which are specific
recommendations to what we're going to discuss

1 now.

2 Mr. Tellechea, do you want to proceed?
3 Mr. McPherson, I'd go ahead and I'll defer this
4 to Mr. Tellechea to read these into the record
5 and then we'll discuss them.

6 MR. TELLECHEA: Let me just set this up
7 first.

8 CHAIRMAN BEARISON: Sure. Go ahead.

9 MR. TELLECHEA: What we're talking about is
10 (M), Training Requirements that are page 11, and
11 as written right now, basically what they're
12 talking -- what we're looking at is Board
13 certification in pain medicine/management,
14 whatever the proper term is, or anesthesia by a
15 Board approved -- by the American Board of
16 Medical Specialities, or any other Board -- or
17 any other Board approved specialty organization
18 approved by the Board of Medicine/Board of
19 Osteopathic Medicine as set forth in their
20 respective rules.

21 (2) At successful completion of a
22 post-graduate training program in pain
23 medicine/management, accredited by ACGME,
24 American Osteopathic Association, College of
25 Family Physicians of Canada, or Royal College of

1 Physicians and Surgeons in Canada. And this is
2 -- what I tried to get it to here is fellowship
3 programs is my understanding.

4 (3) is 50 hours per year of category one
5 AMA or AOA continued medical education in pain
6 medicine/management, and I'm going to need some
7 type of effective date in there.

8 And then (4) current staff privileges at a
9 Florida licensed hospital or pain -- to practice
10 pain medicine or perform pain medicine
11 procedures.

12 Now, these are not "ands" between each of
13 these three different things; these are "ors".
14 If you want "ands" then -- is where we discuss
15 this. Okay?

16 Now, the -- I don't have --

17 CHAIRMAN BEARISON: I have it and I'll go
18 ahead --

19 MR. TELLECHEA: Read it into the record.

20 CHAIRMAN BEARISON: -- and again where this
21 comes from is the Broward Grand Jury and
22 specifically these are the recommendations which
23 were made by the Grand Jury and I'll quote
24 directly number eight.

25 "Your Grand Jury recommends that the

1 legislator consider whether it is appropriate
2 for non-physicians to own pain clinics and
3 whether owners of pain clinics should be
4 physicians."

5 Item nine, "Your Grand Jury recommends that
6 a medical director for a pain clinic be Board
7 certified in pain medicine."

8 Item ten, "Your Grand Jury recommends that
9 only doctors Board certified in pain medicine be
10 allowed to dispense drugs from a pain clinic."

11 Number eleven, "Your Grand Jury recommends
12 that the Board of Medicine and the Board of
13 Osteopathic Medicine establish minimum
14 qualifications and training for physicians
15 working at pain clinics."

16 And I believe those are the items that the
17 Grand Jury recommend and are specific to this
18 discussion.

19 MR. TELLECHEA: Of course the issue of
20 ownership of these clinics, that's beyond the
21 scope of this committee, is being addressed -- I
22 think Senator Erinson has -- Aronberg has a bill
23 that is being -- that is presented and I think
24 it is in your materials where it is going to
25 preclude anyone other than physicians from

1 owning pain management clinics, but that's out
2 there for the legislature to deal with.

3 If any of the members of the committee
4 wants to provide input to Senator Aronberg, he
5 has asked me that you are welcome to do so. You
6 can contact his office and provide some input
7 regarding that. And being that everybody has a
8 constitutional right to petition their
9 legislature for -- you know, you folks out there
10 could do the same thing, of course.

11 Well, this is what we have right now. We
12 have that input from the Grand Jury and it's
13 here for your discussion and review.

14 CHAIRMAN BEARISON: Thank you. I'd just
15 like to remind everybody on the Board and also
16 the audience again, we will not -- I'll say this
17 again -- we will not be discussing the ownership
18 issue because, again, that's a legislative
19 issue. So the ownership issue is not on the
20 table for right now. Very well.

21 If no committee members want to make any
22 opening remarks, then we can go ahead and go to
23 the public for comments.

24 Mr. Beebe?

25 MR. BEEBE: Yes. Just a comment about the

1 "or" aspect of point number three, the
2 continuing medical education, say relative to
3 point number one. Point one identifies pain
4 management physicians and then others that are
5 Boarded. It just strikes me that for those that
6 are Boarded in pain management probably don't
7 need that CME in pain management. But just
8 because you're Board certified in some other
9 specialities and you migrate over to a pain
10 clinic, from my perspective, it doesn't mean
11 that you're moving over there with good quality.

12 MR. TELLECHEA: If you're Board certified
13 in another -- in another specialty, that doesn't
14 -- that doesn't -- you're not -- that doesn't
15 get you into the training requirements. You
16 have to be specifically Board certified in pain
17 management medicine or anesthesia. All right?
18 And if you're -- that Board certification will
19 meet the training requirement.

20 MR. BEEBE: I know. But then it goes on to
21 say "or any other Board approved specialty
22 organization." And so that's the section that
23 I'm referring to.

24 MR. TELLECHEA: No, no, no. That's --

25 MR. BEEBE: No?

1 MR. TELLECHEA: No. That's pain medicine
2 or management or anesthesia by a Board -- by a
3 Board approved by the American Board of Medical
4 Specialty or any other Board approved. That's
5 talking about specialty organizations.

6 MR. BEEBE: Gotcha.

7 MR. TELLECHEA: All right.

8 MR. BEEBE: Gotcha.

9 CHAIRMAN BEARISON: Okay.

10 MR. BEEBE: Thank you.

11 CHAIRMAN BEARISON: All right. What we'll
12 do now is to take time -- and, again, I want to
13 remind our audience of the guidelines for this
14 discussion and the time limit.

15 Sir, go ahead and start please.

16 MR. SLOAN: Yes. Paul Sloan, private owner
17 of a pain management clinic in Venice, Florida.

18 I strongly urge the Board to allow
19 legitimate licensed and active physicians to
20 participate in pain management and medication
21 management by taking the additional CMEs that
22 are required. I would also recommend that they
23 eventually, through the process of the American
24 Academy of Pain Management, become diplomats as
25 the colleague next to me will state that he is.

1 This issue of trying to keep everybody out
2 of this but Board certified doctors is
3 ridiculous. Good physicians should be able to
4 practice pain medication management, pain
5 management, and I'm not talking about
6 interventional procedures without having to be
7 Board certified.

8 Additionally, Board certification is a
9 subspecialty, it's not a specialty. And before
10 you become Board certified you have to be a
11 neurologist, Board certified. You have to
12 physical medicine or anesthesiology.

13 So basically what you're saying is that
14 doctors in the state of Florida would have to be
15 first become Board certified in one of three
16 specialties before they become --

17 MR. TELLECHEA: We're not saying that.

18 MR. SLOAN: Well, yeah.

19 MS. MCNULTY: These are "ors".

20 MR. SLOAN: I'm saying that I want --

21 MR. TELLECHEA: These are "ors" not "ands".

22 MR. SLOAN: -- the -- yes, I want the "or"
23 to continue.

24 MR. TELLECHEA: Okay.

25 MR. SLOAN: I'm concerned that you had said

1 that you could come up and say, you know, we
2 want it "and" and that's my concern. Is that
3 there's going to be a push to make this "and"
4 and that's the concern. So I'm asking that it
5 stay as "ors" and that the 50 CMEs and, again,
6 AAPM also be required.

7 CHAIRMAN BEARISON: Thank you, sir.

8 MR. MCPHERSON: I have a question.

9 CHAIRMAN BEARISON: Mr. McPherson.

10 MR. MCPHERSON: Mr. Sloan, in addition to
11 what's in the draft, those four items, based
12 upon your experience, how long have you had a
13 pain clinic? How many years have you --

14 MR. SLOAN: Three years.

15 MR. MCPHERSON: Three years?

16 MR. SLOAN: Right.

17 MR. MCPHERSON: Can you -- do you have any
18 other ideas that would provide other options or
19 strengthen the --

20 MR. SLOAN: Well I submitted them in
21 writing to all the Board members.

22 MR. MCPHERSON: Could you summarize?

23 MR. SLOAN: I will --

24 MR. MCPHERSON: I'll tell you, we've got
25 stacks. Could you summarize maybe one or two

1 things that --

2 MR. SLOAN: Well, I think --

3 MR. MCPHERSON: -- that could also help
4 strengthen --

5 MR. SLOAN: I think that any doctor --

6 MR. MCPHERSON: -- patient safety?

7 MR. SLOAN: -- that's practicing pain
8 management should become a diplomat with the
9 American Academy of Pain Management, which
10 requires two years of clinical experience and
11 extensive testing.

12 Dr. Miguel here is a diplomat with the
13 American Academy of Pain Management and proudly
14 puts it on his resume. I think it's a great way
15 for physicians that can't meet the subspecialty
16 requirement to practice in pain management.

17 MR. MCPHERSON: Okay. If there's anything
18 else, and this is for everybody, the committee
19 has gotten a lot of stuff, and if you can -- if
20 you could take this draft rule and sort of
21 summarize what you have provided the committee
22 or what you're going to come up with, and then
23 -- and actually send it to us as an addition or
24 substitution or whatever, it really makes a
25 difference in how we're able to address it if

1 you give us specific suggested changes.

2 Thank you.

3 CHAIRMAN BEARISON: Dr. Miguel. And if
4 someone else and other people like to come
5 forward to speak after him.

6 DR. MIGUEL: Rafael Miguel, Florida Society
7 of Anesthesiologists. Only because I was
8 brought up in the prior presenter's discussion,
9 I do want to point out I am Board certified such
10 as it may be by the American Academy of Pain
11 Management. I cannot think of a more worthless
12 organization than that one certifying pain
13 management physicians.

14 And I became that in 1991 when there was no
15 other certifying body for any type of pain
16 physician. As soon as the -- as soon as the
17 American Board of Medical Specialties came out
18 with their subspecialty Board certification exam
19 in pain medicine, which is considered the
20 highest level of Board certification in this
21 country, I took that exam and passed it and
22 recertified last year.

23 So, again, yes, I do hold the AAPM. I
24 recommend it to no one. I would not respect
25 anybody any more because they have it and I have

1 it, and it is on my CV. However, so is the ABMS
2 Board certification.

3 That having been said, I do wish to bring
4 up a couple of issues. There are -- I think
5 this issue is more complex than even this makes
6 it appear, and I think that we're dealing with
7 two different types of pain practices. I think
8 we're dealing with new pain practices and
9 existing pain practices. And to be fair, many
10 physicians who have been in practice doing pain
11 medicine for 15 to 20 years, or 10 to 20 years
12 if you will, started to do so and had not
13 completed fellowship training and had already
14 completed their residencies and other
15 specialities and gravitated slowly into pain
16 medicine, and have been doing a good job and
17 should not be penalized in that regard.

18 Those individuals are going to be the
19 harder ones to deal with with respect to the
20 requirements. Going forward is a much easier
21 issue. We must elevate the quality of the pain
22 -- everyone that holds themselves out to be a
23 pain medicine physician and every office that
24 identifies itself as a pain clinic, we can
25 require no -- nothing less than fellowship

1 training, ACGME fellowship training, AOA, the
2 Canadian Boards, fellowship training to call
3 oneself a pain physician or to identify a clinic
4 as a pain clinic going forward. And I've
5 proposed January 1 of 2010 or as can be allowed
6 by Board rule because I suspect that there may
7 be a challenge to this rule.

8 So, again, going forward I think is fairly
9 simple. Require fellowship training. Require
10 documentation that specialty training has
11 occurred. I know of no fellowship trained
12 physician that runs a pill mill. None. Zero.
13 I know of none. And I know a lot of pain
14 physicians in this state. I know of none that
15 do so.

16 I think that fellowship training absolutely
17 needs to be required and recognized fellowship
18 training is what we should be all about. That
19 will demonstrate that we're serious about this
20 specialty. We're serious about the condition of
21 pain medicine in our state. Okay.

22 CHAIRMAN BEARISON: One quick question.
23 What do you recommend we do as far as these
24 people now? That's -- and you mentioned that's
25 the harder issue and I agree with you.

1 Do you have a specific recommendation
2 regarding that?

3 DR. MIGUEL: And well those -- before I
4 answer your question, and I'm sorry that I took
5 so much time, but the first 45 seconds weren't
6 my time. I was just responding.

7 (Laughter.)

8 The -- between one and two there should be
9 an "or". Between two and three there should be
10 an "and". Between three and four there should
11 be an "and". And that's in your letters that I
12 wrote to you.

13 The -- to answer your question,
14 Dr. Bearison, and that's an excellent question,
15 and it's one that's hard to deal with. I think
16 that looking back at an individual's practice
17 and saying physicians, because we've talked a
18 lot by the Louisiana rules here, and the
19 Louisiana rules did grandfather individuals back
20 to 2005, I believe it was, and the clinics,
21 excuse me, did not grandfather the ones from
22 2005 now, but the ones that existed before then
23 had been grandfathered in. And that may be a
24 reasonable thing. The literal explosion of
25 clinics that we've seen, especially in Broward

1 County, may be an index of where we should be
2 looking at.

3 So I think a combination of documented --
4 documented expertise, privileges at a local
5 hospital to perform pain -- to practice pain
6 medicine and/or interventional pain medicine,
7 and then the CMEs would come in. I would
8 caution you to rely very heavily on CMEs. I
9 don't think they're worth very much.

10 CHAIRMAN BEARISON: Thank you, sir.

11 MR. TELLECHEA: Can I ask him a question?
12 I've got a quick question about fellowship
13 programs?

14 DR. MIGUEL: Yes?

15 MR. TELLECHEA: Are there enough fellowship
16 programs out there for people to get the
17 training?

18 DR. MIGUEL: There are 276 pain fellows
19 actively in training. There are --

20 CHAIRMAN BEARISON: Is that nationwide or
21 statewide?

22 DR. MIGUEL: Nationwide. Nationwide.

23 CHAIRMAN BEARISON: I just want to clarify
24 that.

25 DR. MIGUEL: I know. That's a good

1 clarification.

2 Nationwide there are 276 fellows in
3 training. That seems to satisfy. I recently
4 had a change in occupation from employment and
5 was considered a new physician in Hillsborough
6 and Sarasota Counties where I have pain
7 practices, and Cigna for example will not
8 credential me because they say we're saturated.
9 We don't need anymore pain physicians. It is
10 not an access to care issue in our state. Many
11 physicians are being offered contracts at levels
12 less than, and all my colleagues in the
13 southeast can vouch for this, much less than
14 Medicare rates.

15 MR. TELLECHEA: Well --

16 DR. MIGUEL: And they don't care, there's
17 many of them out there.

18 MR. TELLECHEA: Well, I know that --
19 there's many programs, fellowship programs out
20 there?

21 DR. MIGUEL: Yes.

22 MR. TELLECHEA: To be able to get these
23 people trained?

24 DR. MIGUEL: In the state of Florida
25 there's one, two -- well, there's three in the

1 state of Florida.

2 MR. TELLECHEA: Okay.

3 DR. MIGUEL: Nationwide?

4 MR. TELLECHEA: If we say -- let's say we
5 set up a five-year period for people to get
6 their fellowship training.

7 DR. MIGUEL: Yes.

8 MR. TELLECHEA: Okay. And within five
9 years, you know, five years from now, from there
10 on afterwards, anyone going into pain management
11 has to be fellowship trained.

12 There is enough programs nationwide for all
13 those people who are doing pain management to go
14 in there and get that fellowship training --

15 DR. MIGUEL: In pain management now or new
16 individuals?

17 MR. TELLECHEA: Well, I mean --

18 DR. MIGUEL: Well, there's a difference
19 because it's going to be -- it's going to be
20 enormously -- our programs are very competitive.
21 We get, you know, dozens and dozens if not
22 hundreds of applicants. We only interview a
23 couple dozen for three slots. So they're very
24 competitive programs.

25 MR. TELLECHEA: Uh-huh.

1 DR. MIGUEL: So if you're saying that for
2 new individuals there's no wait time. There's
3 people wanting to move here all the time. My
4 fellows are having a hard time finding jobs
5 because everything is saturated. So they're
6 leaving the state.

7 There is no need for non-fellowship trained
8 physicians going forward. If what you're
9 alluding to is getting the existing pain doctors
10 to become fellowship trained, they're going to
11 find it extraordinarily difficult to compete
12 with new grads just finishing their residency.

13 That's my feeling.

14 CHAIRMAN BEARISON: Okay. Next?

15 DR. CORDNER: Harold Cordner, Florida
16 Society of Interventional Pain Physicians.

17 I'd have to obviously echo what Dr. Miguel
18 said. We also submitted recommendations that
19 between paragraph one and two there was an "or".
20 Between paragraphs two and three "ands".

21 In addition, with the CME credits we
22 recommended that there should be at least six
23 hours of CME credit with opioid and controlled
24 substances, which should include pharmacologic
25 education, patient monitoring and regulatory

1 compliance. That should be very much part and
2 parcel with what we're trying to accomplish here
3 and not just CMEs in pain management, but opiate
4 controls and substance management.

5 I would also have to again second
6 Dr. Miguel's recommendations that from January
7 1, 2010 --

8 DR. MCCANN: He didn't make a motion, so
9 you can't second it.

10 DR. CORDNER: -- that we go forward with
11 requiring a minimum of fellowship training if
12 not Board certification for people coming in as
13 of January 1, 2010.

14 CHAIRMAN BEARISON: Sir, please identify
15 yourself.

16 DR. WEBSTER: Dr. Paul Webster, owner of a
17 pain management clinic here in Kissimmee,
18 Doctors Pain Management Associates.

19 I would like to emphasize, again, I would
20 like to echo what Dr. Miguel said, that there
21 should be an "and" between three and four, at a
22 minimum should be an "and".

23 Additionally, if the purpose of this
24 meeting and the overall goal is to reduce abuse
25 and diversion in pain management, I think that

1 there should be stricter requirements in terms
2 of CMEs. It should be made more difficult for
3 non-qualifying physicians to be medical
4 directors of pain clinics. Therefore, I would
5 suggest that at a minimum it should be 60 or 75
6 hours per year recommended in terms of the CMEs.

7 Additionally, I agree with Dr. Miguel, I
8 was also a 1990 certified by the American
9 Academy of Pain Management and as the Board
10 knows it's not recognized in the state of
11 Florida, so nobody could legitimately offer that
12 as a Board certification.

13 CHAIRMAN BEARISON: Thank you, sir.

14 Ma'am?

15 DR. LEGRANDE: Once again, my name is
16 Dr. Sydel LeGrande. I am a family practice
17 physician. I am not a pain management
18 physician, but I practice in my practice pain
19 management, if that makes sense.

20 I don't do any invasive procedures; I'm not
21 interested in being a pain management physician
22 in the -- in the clearest sense of the word.

23 I'm a little confused because I'm trying to
24 make a real determination as to what we're
25 talking about in regards to providing pain

1 management to patients who have chronic pain.
2 As a primary care physician, I've been doing
3 this for the last 25 years of my practice. I've
4 been in practice for almost 20 years, not 25.
5 And I don't -- I've been doing this as a primary
6 care physician with the onslaught of these
7 non-physician owned clinics throughout our
8 community. The whole climate has changed and
9 I'm sure that's why we're here.

10 My concern is, is that if legislation goes,
11 if rules are changed in regards to my basic way
12 and most primary care physicians' basic way of
13 writing medications, if we have patients with
14 chronic pain that have graduated from
15 anti-inflammatories to hydrocodone, to
16 oxycodone-10, to oxycodone-15, to oxycodone-30,
17 and you've been managing them for the last three
18 to four or five years watching what's going on
19 with them, I mean, am I going to, as a primary
20 care physician, not be able to do that anymore
21 if I have to be a pain management Board
22 certified physician?

23 I'm never going to -- I don't even do
24 trigger points. I don't -- I don't do any
25 invasive procedures. I'm not interested in

1 being a pain management physician. Love family
2 practice. So I need to understand where we
3 stand as primary care physicians. We refer out
4 all the time, but we refer out because DEA is
5 monitoring.

6 CHAIRMAN BEARISON: Okay. All right.
7 Mr. McPherson?

8 MR. MCPHERSON: Doctor, two questions. Are
9 you Dr. LeGrande?

10 DR. LEGRANDE: Yes, sir.

11 MR. MCPHERSON: Okay. The statute provides
12 that pain management clinic rules apply to
13 clinics that advertise as pain management. Do
14 you -- are you fitting in that category?

15 DR. LEGRANDE: Yes, I --

16 MR. MCPHERSON: Oh, you do.

17 DR. LEGRANDE: -- I fit in the category
18 only because I have patients who come to me for
19 pain management specifically.

20 MR. MCPHERSON: But you advertise pain
21 management?

22 DR. LEGRANDE: No.

23 MR. MCPHERSON: Okay. So you don't
24 advertise pain management.

25 Now, the second category is if -- are you

1 in solo practice?

2 DR. LEGRANDE: Yes, sir.

3 MR. MCPHERSON: If more than half of your
4 patients are receiving scheduled drugs --

5 DR. LEGRANDE: No.

6 MR. MCPHERSON: Okay. So --

7 UNIDENTIFIED SPEAKER: It doesn't apply to
8 you.

9 MR. MCPHERSON: It doesn't apply to you.

10 DR. LEGRANDE: Okay.

11 MR. MCPHERSON: I know that may seem -- it
12 doesn't apply to you.

13 DR. LEGRANDE: Well, I understand. I know
14 that. I understood that. But this is my
15 concern. It's increasing every day because of
16 word of mouth. And so my patients are growing
17 and I'm afraid that it will get -- I mean, where
18 do I draw the line? I say, okay, I can't accept
19 anymore patients who are interested. You see?

20 So that's where I am today, but where will
21 I be three years from now especially when this
22 legislation --

23 MR. TELLECHEA: Well, can I just say the
24 problem is, is once you reach a point where 50
25 percent or more of your practice is pain

1 management --

2 DR. LEGRANDE: Then it switches.

3 MR. TELLECHEA: -- then you're no longer a
4 primary care physician.

5 DR. LEGRANDE: I understand.

6 MR. TELLECHEA: You're becoming a pain
7 management physician.

8 DR. LEGRANDE: And I don't -- I don't want
9 to do that.

10 CHAIRMAN BEARISON: And I think that's the
11 answer to your question.

12 DR. LEGRANDE: Thank you.

13 CHAIRMAN BEARISON: Thank you, ma'am.

14 Dr. Escher?

15 DR. ESCHER: Yes. I was just going to make
16 an observation that you said "word of mouth" and
17 that sets off alarm bells with me. You've moved
18 from a love of family practice to a love of --

19 DR. LEGRANDE: No.

20 DR. ESCHER: -- pain management.

21 DR. LEGRANDE: No, I don't. Now let me
22 explain something to you.

23 DR. ESCHER: You have to -- you have to
24 control your patient --

25 DR. LEGRANDE: Yes.

1 DR. ESCHER: -- selection.

2 DR. LEGRANDE: Absolutely. And that's one
3 of the things. This is what is happening.
4 Because I had an experience, as I told you
5 before, with a pill mill and I know what goes on
6 there and I can give you all kinds of insight on
7 that. I hate it so badly and detest what has
8 happened that when -- when people who -- who are
9 legitimate, who really have chronic pain, know
10 that they have a family physician that can take
11 care all of their health care needs as well as
12 their pain issues, then they come. That's what
13 I mean by word of mouth. Because patients talk
14 to each other. And they're having a hard time
15 finding real doctors who will take care of them
16 because these places out here are, you know, in
17 some cases are not doing right by the patient,
18 not even listening to them and hearing what's
19 going on with their -- with their issues.

20 DR. ESCHER: But it's the purpose of this
21 Joint Committee to establish standards for pain
22 clinics --

23 DR. LEGRANDE: Yes, sir.

24 DR. ESCHER: -- legitimate pain clinics.

25 DR. LEGRANDE: I understand.

1 DR. ESCHER: Not to try to move family
2 practice clinics along that have drifted into
3 pain. Do you understand?

4 DR. LEGRANDE: I do understand.

5 DR. ESCHER: And I don't want to see you
6 come before either Board in trouble in three
7 years, you know where this is going.

8 DR. LEGRANDE: Uh-huh.

9 DR. ESCHER: You've got to be careful. And
10 that's what I would tell anybody in the audience
11 that finds their practice starting to run ahead
12 of them with more than half of the patients
13 coming just for pain medications.

14 DR. LEGRANDE: Well that's why I want to
15 understand what the standards are now before,
16 because if that does happen, especially with the
17 changes that's occurring now and my patient
18 populations grows, I want to be in compliance; I
19 want to do what is correct. But I don't think I
20 need to be Board certified in pain management,
21 and that was my -- that was my concern.

22 DR. ESCHER: One other comment that I
23 wanted to make as -- I do anesthesiology and
24 pain management and I'm Board certified in both.
25 One thing this clinic -- this committee has to

1 understand is it's not our job to shepherd
2 people along who have made a mid-career decision
3 to start doing a specialty they weren't trained
4 in, a specialty they're not Boarded in.

5 My advice, go do a neurology residency. Do
6 an anesthesiology residency. Do a physiatry
7 residency. If I told you today I wanted to be a
8 dermatologist, I'm going to have to go do a
9 dermatology residency. You're not going to come
10 up with a CME scheme and a practice scheme
11 that's going to allow me to open a dermatology
12 clinic.

13 DR. LEGRANDE: Right.

14 DR. ESCHER: So my advice to anyone who
15 anticipates doing pain management in this
16 regulatory environment is to go back and be
17 retrained.

18 DR. LEGRANDE: And I guess, once again, I
19 believe the question is: What are you calling
20 pain management in general? And I recognize
21 there is a definition for that. I understand
22 that.

23 DR. ESCHER: Right.

24 DR. LEGRANDE: But in the case -- in the
25 reality of the sense of primary care, pain

1 management has always occurred.

2 DR. ESCHER: Correct.

3 DR. LEGRANDE: So that is -- that is my
4 point. So it does not -- it does not go beyond
5 the scope of what I generally do and what
6 primary care physicians have done. So it's not
7 a matter of me going out to be retrained to do
8 what I've already been doing. That is not --
9 that is not the issue at all.

10 I'm not trying to do something that I have
11 not been already trained to do.

12 DR. ESCHER: But we -- we've been charged
13 to come up with standards --

14 DR. LEGRANDE: Right.

15 DR. ESCHER: -- and to me you're operating
16 as a pain clinic now. You've moved beyond
17 family practice. You might as well put pain
18 management under your name.

19 DR. LEGRANDE: And if I do that, and I
20 don't have a problem in doing that, as long as I
21 continue to do what I'm doing. I want to make
22 sure that what you're saying -- if I have to be
23 Board certified in pain management to do what
24 I've been doing for 20 years, that is the reason
25 why I'm sitting here. So if all I'm doing is

1 what I've been doing, is simply writing scripts
2 and following -- I even have an addiction --

3 DR. ESCHER: I understand.

4 DR. LEGRANDE: -- counselor.

5 DR. ESCHER: I understand. But we have to
6 come up with standards for the whole state of
7 Florida here.

8 DR. LEGRANDE: I understand. I understand.
9 Thank you.

10 CHAIRMAN BEARISON: Okay. Thank you.

11 Sir?

12 DR. SHERMAN: Scott Sherman, previously
13 identified.

14 I'll try to be brief.

15 CHAIRMAN BEARISON: And specific to this
16 issue, please.

17 DR. SHERMAN: Exactly. Exactly.

18 I'll try to propose a little bit of an
19 alternative. Mandating that everybody moving
20 forward has to be Board certified -- excuse me
21 -- fellowship trained in pain medicine has -- is
22 somewhat problematic because I think 95 percent
23 of the fellowship training schemes are through
24 anesthesia residencies. They focus heavily on
25 interventional pain. Almost to the exclusion in

1 some of the programs, and I've seen them
2 personally, of the medical management, and the
3 medical management is the big concern of this
4 Board it seems from what's going on with pill
5 mills and everything else.

6 I sat, in my residency in physiatry, spent
7 three years dealing with people with
8 musculoskeletal pain and writing medical
9 management prescriptions for these people as
10 well as learning interventional techniques.

11 I rotated along with the interventional
12 pain physicians in Buffalo, New York. They
13 spent six months on the inpatient ward of a
14 cancer hospital dealing with PCA pumps and six
15 months in an interventional pain clinic doing
16 almost no medical management. And many, not all
17 of them, I'm sure some of the programs are much
18 more well-rounded, but some of them are not.

19 So one way to expand this slightly is to,
20 you know, you have Board certification and pain
21 management or anesthesia. At least add
22 neurology and physical medicine and
23 rehabilitation, the other two specialties that
24 deal with these kinds of problems on an ongoing
25 basis and are eligible to do accredited

1 fellowships.

2 CHAIRMAN BEARISON: I'm sorry. You said
3 neurology and what was the other one?

4 DR. SHERMAN: The three -- the three
5 medical specialties that are eligible to sit --
6 to participate in an accredited fellowship
7 program --

8 CHAIRMAN BEARISON: Uh-huh.

9 DR. SHERMAN: -- are anesthesia, neurology
10 and physical medicine and rehabilitation.

11 AUDIENCE MEMBER: No.

12 DR. SHERMAN: And there are some -- I think
13 there are some small possible exceptions, family
14 practice or emergency medicine, but those are
15 the three that make up 99 percent of the pain
16 fellows in this country as far as I know. If
17 somebody has statistics and can show me
18 differently, I would be open to looking at them.

19 But I mean, many times in our training we
20 spend more time dealing with things that are of
21 concern here than people who actually do
22 fellowships.

23 CHAIRMAN BEARISON: Okay. Thank you for
24 your comment.

25 Dr. Escher, did you want to say something

1 before our next speaker?

2 DR. ESCHER: I was just going to say that
3 this may be a difficult issue to fully put to
4 rest today. Perhaps what we can do is find out
5 in terms of manpower and womanpower the number
6 of neurologists and physiatrists and
7 anesthesiologists who are available in the state
8 of Florida. Because I do agree, there are --
9 the pain fellowships were open to other
10 specialties. That was a decision that the
11 American Board of Anesthesiology worked out with
12 those other Boards a few years back. So I think
13 he does have a good argument about that. I
14 don't think you can restrict it just to
15 anesthesia.

16 CHAIRMAN BEARISON: Thank you.

17 Ma'am?

18 DR. GOLDEN: Marla Golden, the Florida
19 Academy of Pain Medicine.

20 I think we're in an exciting and difficult
21 time. I think everyone in this room is
22 committed to moving this process forward and
23 doing the right thing for the patients in our
24 state and even nationally.

25 With regard to the language on line six,

1 page eleven, I would like to request that after
2 "approved by the American Board of Medical
3 Specialties" there be a comma and the "American
4 Board of Pain Medicine" be added since it is a
5 Board that is recognized by the State of
6 Florida.

7 They and their criteria for Board
8 certification includes fellowship training. It
9 includes physicians who are and originally were
10 determined to be from five major specialties of
11 origin and it requires them to be residency
12 trained.

13 I'm going through this because I think
14 there's a need to understand the very big
15 picture. Those five specialties were
16 psychiatry, neurosurgery, neurology, anesthesia,
17 physical medicine and rehabilitation.

18 That being said, as an emergency physician
19 whose is residency trained and Board certified,
20 I made application to that Board and was allowed
21 to sit for that certifying exam based on other
22 criteria that, as I've said, has been evaluated
23 by the State and determined to allow us to claim
24 to be Board certified.

25 Fellowship training is an excellent and

1 wonderful process that is taking place across
2 the country and it is the best thing we can do
3 right now with regard to training pain medicine
4 physicians, and that is because we have these
5 specialties of origin. We have an evolving
6 specialty of pain medicine that has people
7 coming in recognizing this public health issue,
8 recognizing that it is a bona fide specialty.

9 However, we do not have that recognition
10 from the American Board of Medical Specialties
11 that has become the agency or the organization
12 that kind of deems a specialty to be recognized.

13 The intention of the American Board of Pain
14 Medicine is to develop a cohesive pain medicine
15 specialty that will include interventional
16 physicians as well as other physicians within
17 that specialty who may or may not do
18 interventions and may do little needles all the
19 way up to big needles. There will be a
20 comprehensive specialty that addresses every
21 aspect of interdisciplinary or multimodal
22 comprehensive pain treatment.

23 And so the recommendation for fellowship
24 training is good. However, the big picture will
25 provide that as we get recognition as a

1 specialty that actual residency training will
2 take place.

3 That doesn't really help us right now
4 today; we're not there. We are in a place where
5 there are very fine physicians who for one
6 reason or another may or may not have sat for a
7 Board certification exam --

8 CHAIRMAN BEARISON: Ma'am, you have 30
9 seconds.

10 DR. GOLDEN: Thank you. And any specialty,
11 we have physicians who have done all the
12 training.

13 I would respectfully request that we leave
14 the "ors" in after each clause, that we consider
15 using a 50 hour every two years for the CME, and
16 that we be very careful to understand that every
17 physician can and should treat and address pain
18 in all of their patients. We need a critical
19 interface with our primary care physician
20 colleagues and I think to destroy that or to sit
21 in a place of elitism and say that, you know,
22 they should just decline that aspect of care is
23 short-sighted and narrow minded.

24 CHAIRMAN BEARISON: Okay. Thank you.

25 DR. GOLDEN: Thank you.

1 CHAIRMAN BEARISON: Okay. Sir, you are
2 recognized.

3 MR. CARPENTER: I'm David Carpenter,
4 Southeast Florida Pain Management.

5 You know, we see a lot of patients right
6 now that are inoperable. I mean, rather they --
7 they don't have insurance; they don't have the
8 ability to do anything else. They're self pay.
9 And a lot of the anesthesiologists and physical
10 rehabilitation docs, they won't see them. They
11 won't -- they won't let them into their
12 practice.

13 So by doing that, because a lot of the
14 anesthesiologists and pain docs, they want to do
15 procedures. You know, they want to do epidurals
16 and patients just don't have the money or the
17 means to do that. So they're only option that
18 they have is medical pain management.

19 If you try to -- if you take away the
20 ability for other physicians to manage their
21 pain medically you're going to have problems
22 with a lot of overflow. There's not going to be
23 enough physicians to cover, and there's -- you
24 know, those patients are going to suffer.

25 CHAIRMAN BEARISON: Thank you.

1 Mr. Nuland? Mr. McPherson?

2 MR. MCPHERSON: (Not using microphone.)

3 Was that Doug Carpenter?

4 CHAIRMAN BEARISON: Sir?

5 MR. CARPENTER: David Carpenter. David.

6 MR. MCPHERSON: (Not using microphone.)

7 David. Mr. Carpenter, do you happen to know
8 whether or not physicians who practice in pain
9 management that are not Board certified, are
10 they routinely excluded from privileges or do
11 they get privileges in hospitals who are Board
12 certified?

13 MR. CARPENTER: I really can't --

14 MR. TELLECHEA: You need to sit down and
15 talk into the microphone.

16 MR. CARPENTER: Okay. I really can't
17 answer for you as far as what they -- what they
18 are doing or not doing. I know that, you know,
19 that a lot of -- a lot of the physicians -- I
20 know all of the physicians at our facilities go
21 and they -- you know, they continue their
22 education. They get the CMEs in at American
23 Academy of Pain Management, American Academy of
24 Pain Medicine, and they continue to, you know,
25 do things. They were specialized in rather --

1 you know, general surgery, orthopaedics and that
2 kind of stuff.

3 MR. MCPHERSON: Okay. This is one of those
4 four options. I was wondering if number four is
5 a good option for physicians who are not Board
6 certified.

7 Thank you.

8 CHAIRMAN BEARISON: No. We're going to go
9 right down the line.

10 Mr. Nuland.

11 MR. NULAND: Chris Nuland. Following up on
12 Dr. Miguel and Dr. Golden's comments, in line
13 13, if you want to create a grandfathering
14 provision we recommend that that line start
15 "three years of clinical experience prior to
16 January 1st, 2013, and 50 hours per biennium.

17 By using that language, you essentially
18 close the door to anyone who is not practicing
19 as of January 1st, 2010, going forward, and you
20 create that grandfathering, but you slam the
21 door on future people.

22 CHAIRMAN BEARISON: Thank you.

23 MR. NULAND: Thank you.

24 CHAIRMAN BEARISON: Thank you for that
25 concise comment.

1 Next?

2 MS. DUENSING: My name is Lenny Duensing,
3 I'm the director of the American Academy of Pain
4 Management, and I just wanted to clarify some
5 misconceptions about the Academy and its
6 credential and just say who we -- just explain
7 who we are.

8 The American Academy of Pain Management has
9 been around for 20 years and our focus has
10 always been on interdisciplinary pain
11 management. We have now moved into the area of
12 integrative pain management. We provide a
13 credential in integrative pain management and
14 interdisciplinary pain management that
15 demonstrates a clinician's understanding of the
16 various ways that pain can be treated. It is
17 not Board certification. We are not proposing
18 that it be compared to the others. I just want
19 to make that clear. That is not -- that is not
20 our purpose.

21 I mean, we feel it is a valuable credential
22 and now that we're moving into integrative it
23 really does -- it does look at pain in a way
24 that we believe that it needs to be treated and
25 that is with a multimodal approach, but it is

1 not Board certification. We are not putting it
2 up -- we're not comparing it to the Board
3 certification that are mentioned here. I just
4 wanted to make that clear.

5 We do provide, however, outstanding
6 education and I have a question for you. We do
7 at our annual meeting and through our
8 publications through out monographs, provide
9 excellent education in opioid prescribing. And
10 I'm curious. I just came back from an FDA
11 meeting, from a REMS meeting where they're
12 looking at very similar types of issues and who
13 can prescribe, who is really -- you know, what
14 types of physicians can be prescribers. And one
15 of the things that they looked at was having --
16 you know, having family physicians, people who
17 are not Board certified take -- be required to
18 take continuing medical education, be required
19 to take -- what they came up with was four hours
20 of continuing medical education on prescribing,
21 and I'm wondering whether -- and they talked
22 about CLEPing-out. You know, if you have -- if
23 you can demonstrate that you have experience in
24 pain management, as many good family physicians
25 have in this state, is there a way that they can

1 demonstrate their competence in pain management
2 and be able to practice?

3 CHAIRMAN BEARISON: Okay. Thank you.

4 Mr. Tellechea?

5 MR. TELLECHEA: I have a comment.

6 MS. DUENSING: Okay.

7 MR. TELLECHEA: Well, you know, there is a
8 mechanism in Florida where you can get a waiver
9 or a variance from a particular rule.

10 MS. DUENSING: Yeah.

11 MR. TELLECHEA: It's under Chapter 120. It
12 provides -- it's a petition for variance and
13 waiver.

14 MS. DUENSING: Uh-huh.

15 MR. TELLECHEA: So if you don't meet any of
16 these rule requirements and you can come up with
17 a valid reason why you don't meet the rule
18 requirements you can file that petition for
19 variance and waiver and you can get a particular
20 rule provision waived or a variance from it for
21 a certain period of time or for permanently.

22 So there may be a mechanism for people like
23 that if they don't meet the strict rule
24 requirements.

25 MS. DUENSING: Yeah. I think that should

1 be clarified. I mean, because I think there's a
2 lot of fear that there's -- you know, there are
3 people who have been very good -- very good
4 physicians may not -- you know, are going to be
5 out of business. And, you know, they're doing
6 very good pain management.

7 MR. TELLECHEA: Well, the variance and
8 waiver provision is applicable to any rule
9 promulgated by a Florida -- by an agency of the
10 State of Florida. So it's part of Chapter 120,
11 which is the Administrative Procedure Act.

12 So, I mean, it's not -- it would not just
13 be applicable to this rule, but it would be
14 applicable to any rule.

15 MS. DUENSING: Just anything.

16 MR. TELLECHEA: Yeah.

17 MS. DUENSING: Okay. Thank you.

18 CHAIRMAN BEARISON: Okay.

19 DR. MIGUEL: Mr. Bearison? Dr. Bearison?

20 CHAIRMAN BEARISON: Sir? This will be the
21 last comment. I think everybody else has
22 spoken.

23 DR. MIGUEL: A lot has been mentioned and
24 some of it inaccurate, and I just want the Board
25 to be very clear on some of the different

1 organizations and categories and fellowships and
2 the rest, because serious misinformation was
3 provided and it's probably just lack of
4 knowledge.

5 There are four residencies only that are
6 allowed to sponsor ABMS Board certification --
7 Board fellowship, ACGME and ABMS Board
8 fellowship programs -- anesthesiology,
9 neurology, psychiatry -- neurology and
10 psychiatry, which is considered one -- and
11 ABPM&R.

12 Okay. Those are the only four --

13 CHAIRMAN BEARISON: Sir, what was the last
14 one?

15 DR. MIGUEL: Anesthesiology, neurology,
16 psychiatry --

17 CHAIRMAN BEARISON: Neuro-psyche.

18 DR. MIGUEL: ABPM&R.

19 UNIDENTIFIED SPEAKER: What's that?

20 MS. MCNULTY: Yeah.

21 DR. MCCANN: Physical medicine and
22 rehabilitation.

23 MS. MCNULTY: Thank you.

24 DR. MIGUEL: So those are the only four
25 that are allowed to sponsor fellowships in pain

1 medicine. They sit for the exact exam. Okay?
2 The exam given to fellows in all those
3 disciplines take the exact examination.

4 There are no fellowship programs in the
5 country today sponsored by psychiatry
6 departments. The vast majority, 87, are
7 sponsored by anesthesiology. There are six or
8 seven sponsored by physical medicine/rehab and
9 another four and five by neurology.

10 That allows you to sit for those fellowship
11 examinations and you must have completed a
12 residency in anesthesia to sit for the exam
13 through the American Board of Anesthesiology.
14 You must have completed a residency in physical
15 medicine and rehabilitation to sit for the exam
16 through the American Board of Physical Medicine
17 and Rehabilitation and you must have completed
18 an ACGME accredited residency program to sit for
19 the examination through neurology and
20 psychiatry.

21 That means that it is not limited to
22 anesthesiologists, physical medicine,
23 neurologists and psychiatrists; it allows any
24 specialty. I graduated an internal medicine
25 doctor three years -- four years ago from our

1 fellowship program. She was Board certified --
2 she became Board certified in internal medicine
3 --

4 CHAIRMAN BEARISON: Doctor, you've got
5 about a minute left. I'm sorry.

6 DR. MIGUEL: That's all. I just wanted to
7 point these things out.

8 CHAIRMAN BEARISON: Okay.

9 DR. MIGUEL: Because there was a little
10 misinformation there and I wanted the Board just
11 to be clear about all these.

12 MR. BEEBE: But finish that. The internal
13 medicine doctor graduated from one of your
14 programs. Continue.

15 DR. MIGUEL: Graduated from an
16 anesthesiology program in my fellowship and took
17 the exam through the American Board of Neurology
18 because they allow other disciplines to sit.

19 Dr. Escher completed an anesthesiology pain
20 medicine fellowship and he sat through
21 anesthesiology. And the only ones that have
22 that restriction are anesthesiology and physical
23 medicine and rehab. You can sit through
24 neurology and I believe you can sit through
25 psychiatry, but I can't swear to it.

1 DR. MCCANN: Mr. Chairman, I'd like to say
2 one thing. I've heard a lot of comments from a
3 lot of people today. They're 7,000 people dead
4 in this state from prescription drugs over the
5 last three years. That's one of the reasons
6 this Board is here.

7 What we need is suggestions from you on how
8 to stop something like that. We have people
9 dying from legitimate prescription drugs. We
10 have kids out there that come into my ER all the
11 time and say "there's nothing wrong with this,
12 it's safe because a doctor wrote for it."
13 That's the problem we're having.

14 This isn't a turf war between
15 anesthesiologists and pain medicine specialists.
16 This is to protect the public health and safety,
17 and that's what we need to start considering
18 when we're making our comments here. That's why
19 this Board is here.

20 CHAIRMAN BEARISON: All right. In the
21 interest of fairness, if anybody has not spoken
22 yet on this subject I'll recognize them. If
23 you've spoken already -- is there anybody who
24 hasn't spoken yet? (No response.)

25 Okay. Now, Mr. Tellechea, did you want to

1 make a comment before I finish what I was going
2 to say?

3 MR. TELLECHEA: I don't know -- are you
4 folks ready to make some suggestions as to what
5 you want to see in this provision? Do we want
6 to wait until the next meeting when all the
7 members are here?

8 I mean, this -- I can assure you this is
9 probably the most contentious area of this rule,
10 and this is going to be the one that probably is
11 going to get the most attention once it -- you
12 know, once we get it promulgated. So --

13 DR. MCCANN: Mr. Chairman, I'd like to make
14 a motion that we wait until next meeting when
15 all members are here and that we entertain any
16 suggestions in writing that are going to protect
17 the public health and safety and talk about the
18 proper training to do that.

19 CHAIRMAN BEARISON: Okay. Is there a
20 second for discussion?

21 DR. ESCHER: Second.

22 CHAIRMAN BEARISON: Okay. Discussion for
23 Board members?

24 Dr. Escher?

25 DR. ESCHER: I agree. And I just want to

1 make a couple of points even though we're not
2 going to take this up until the next meeting.

3 The American Academy of Pain Management, I
4 think their leadership, whoever is here from
5 them, should take this back to them. I think
6 they should stop offering this diploma that I
7 see popping up on CVs all the time with docs
8 coming before our Board who are in trouble
9 saying, "Well, I sat for an exam with the
10 American Academy of Pain Management, so that
11 gives me the right to practice this way." I
12 think they should -- they should remove that.

13 Now, CME. I think the American Academy of
14 Pain Management may have beneficial CME. I'm
15 not criticizing that. I think it is a good
16 organization in that sense. Certainly,
17 integrative and multimodal pain practice is in
18 any legitimate pain fellowship in this country.

19 That having been said, anyone in the state
20 of Florida who has drifted into pain practice,
21 it's not our job to rehabilitate your career.
22 You chose to go into the specialty that you did,
23 and so I really don't have a lot of sympathy for
24 people who trained in infectious disease or a GP
25 who didn't finish their residency or they

1 couldn't get Board certified, and now all of the
2 sudden they want to open a pain clinic or maybe
3 they've had a pain clinic open for a few years.

4 I'm very skeptical about someone coming
5 before this Joint Committee and saying, "Look,
6 I've been doing this for ten years; I know what
7 I'm doing."

8 Third, I think that a pain fellowship,
9 regardless of which speciality it is, but I
10 think completion of a pain fellowship or a Board
11 certification in at least your primary specialty
12 should be the minimum that this committee should
13 expect.

14 And I certainly will do some research
15 before the next meeting to see what our person
16 power is for the state of Florida in terms of
17 the four different specialties that can do pain
18 fellowships. But -- and oddly enough, I think
19 that I'm not quite in favor of this whole CME
20 thing. I have to agree, I don't really think
21 there's a lot of good, legitimate CME out there
22 that I think is going to entitle someone to say,
23 "Look, I do a lot of pain CME; therefore, I can
24 practice as a pain doctor."

25 I mean, I worked four to five years to get

1 certified in anesthesiology and pain management.
2 It's a very difficult road. I don't think you
3 can take my education and training and say,
4 "Well, look, I go to three weekends a year and I
5 should have the same right to operate a pain
6 clinic as you."

7 I think that if this Joint Committee ends
8 up recommending that, it doesn't really matter
9 if it's 50 hours a year or 25 or a hundred hours
10 a year of CME. I don't have confidence in that
11 for the public health and safety of this state.

12 So those are just the comments I wanted to
13 make before the next meeting.

14 (Applause.)

15 MR. TELLECHEA: You know, I don't have -- I
16 don't have a say, nor do I want one as to what
17 the training requirements are going to be in
18 this area, but I do know that I am going to
19 ultimately have to defend them probably.

20 So if you go down the road of Board
21 certification or fellowship training, I am going
22 to probably -- you know, somebody may challenge
23 -- this is arbitrary and capricious, and the
24 first thing they're going to say is, "Well, no
25 other area of practice in Florida do you require

1 Board certification or fellowship training."

2 So if that's what you're going to require I
3 want to make sure that we get into the record
4 why that is justified in this particular area of
5 practice and not in every other area of
6 practice. And that may be a very -- I mean,
7 that -- that's fine. But I want to be able to
8 put forward a strong argument why that's going
9 to be required, because I can assure you right
10 now, that is going to be the number one area
11 that's going to be challenged. And the number
12 one argument is going to be why pain management
13 and not cardiology, general surgery, you know,
14 general practice and all those areas also.

15 So that's one thing that we absolutely have
16 to have into the record.

17 MR. BEEBE: Mr. Chair?

18 CHAIRMAN BEARISON: Sir?

19 MR. BEEBE: Ed, do you think it helps your
20 cause on that point if the requirement, say, for
21 the Board certification is in the future at some
22 particular benchmark like Mr. Nuland mentioned,
23 three years down the road, four years down the
24 road, as opposed to right now. How does it
25 affect your legal challenges with that?

1 MR. TELLECHEA: Well --

2 MR. BEEBE: If at all. It may not. I just
3 want to hear from you.

4 MR. TELLECHEA: Yeah, I think it may be
5 helpful to do that.

6 MR. BEEBE: Uh-huh.

7 MR. TELLECHEA: And I think it would -- it
8 would help in the area -- well, actually,
9 probably as to whether the issue would be ripe
10 at all.

11 MR. BEEBE: Uh-huh.

12 MR. TELLECHEA: You know, a ripeness issue
13 or a standing issue for somebody ultimately if
14 they bring the rule challenge. It may -- you
15 know, they may not have that standing
16 immediately, but once it affects them somewhere
17 down the road then they may obtain the proper
18 standing to go ahead and challenge it.

19 MR. BEEBE: Uh-huh.

20 MR. TELLECHEA: So --

21 MR. BEEBE: Thank you.

22 CHAIRMAN BEARISON: All right. There's a
23 motion on the floor. Would you please repeat
24 that so we know what we're voting on. I think
25 Dr. McCann made it.

1 DR. MCCANN: The motion was to table this
2 until the next meeting when all members are
3 available and to accept public comments that,
4 you know, protect the public health and safety
5 and aren't just territorial.

6 DR. ESCHER: Second.

7 MR. BEEBE: Second.

8 CHAIRMAN BEARISON: There's a motion on the
9 floor and it's been seconded.

10 All those in favor, please raise your right
11 hand. (Board members responded.)

12 Opposed? (No response.)

13 What I will instruct staff to do is to make
14 sure that in everybody's packet before the next
15 meeting there is a transcript specifically of
16 this section or discussion so the members that
17 weren't here will be able to go ahead and read
18 that and digest it and can see the information
19 that was presented to us, and what the concerns
20 of everybody was.

21 MR. MCPHERSON: So that -- for the court
22 reporter that will be Training Requirements.
23 That will be that section.

24 CHAIRMAN BEARISON: Yes, sir.

25 MR. MCPHERSON: And were there any other

1 sections that you tabled that you would want a
2 transcript from?

3 CHAIRMAN BEARISON: I don't think we tabled
4 anything else other than to send some stuff back
5 for revision.

6 MR. MCPHERSON: Okay.

7 CHAIRMAN BEARISON: I think that was the
8 gist of the time that we spent when the other
9 members were gone. That included all the public
10 testimony that we didn't have here.

11 MR. MCPHERSON: Thank you.

12 CHAIRMAN BEARISON: Mr. Tellechea?

13 MR. TELLECHEA: You done, Larry?

14 MR. MCPHERSON: (Nodded head.)

15 MR. TELLECHEA: By the way, also, when we
16 talk about submitting public comments, you need
17 to get it to us within the next two weeks so we
18 can give it to the Board members in advance of
19 the meeting.

20 Because, quite frankly, coming to the
21 meeting with handouts is pretty worthless,
22 because I can assure you that none of these
23 Board members are going to be sitting here
24 during the meeting and reading your materials
25 and digesting them here at the meeting.

1 So if you're going to provide the written
2 materials, written comments, do it in advance of
3 the meeting. And, Kaye and Larry, how far in
4 advance do you want it so we can put it on the
5 agenda material? Christy?

6 MS. ROBINSON: It needs to be in our office
7 within the next two weeks because this next
8 meeting is less than a month away.

9 UNIDENTIFIED SPEAKER: What's the date?

10 MS. ROBINSON: I don't have a calendar in
11 front of me.

12 (CROSSTALK.)

13 DR. MCCANN: December 19th.

14 MS. ROBINSON: The date of the next meeting
15 is December 19th. So, I mean, just roughly two
16 weeks from now and that way we have an
17 opportunity to give the members, you know, an
18 ample amount of time to review everything.

19 CHAIRMAN BEARISON: Okay. Thanks.

20 (This concludes this portion of the
21 November 2009 Board of Medicine and Osteopathic
22 Medicine Pain Management Clinic Standards of
23 Practice Joint Committee Meeting.)

CERTIFICATE OF REPORTER

STATE OF FLORIDA

SS:

COUNTY OF SEMINOLE

I, CYNTHIA R. GREEN, Court Reporter, hereby certify that I was authorized to and did report the November 2009 Board of Medicine and Osteopathic Medicine Pain Management Clinic Standards of Practice Joint Committee Meeting; that a review of the transcript was requested; and that the transcript is a true and complete record of my notes and recordings.

I further certify that I am not a relative, employee, attorney or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorneys or counsel, nor am I financially interested in the outcome of the foregoing action.

DATED this 15th day of December, 2009.

CYNTHIA R. GREEN, Court Reporter
Notary Public-State of Florida