

# Oregon Board of Radiologic Technology (OBRT) Legislative Update Board Meeting

## November 15, 2007 MINUTES

State Office Building      800 NE Oregon Street, Room 1B      Portland, Oregon

### ATTENDANCE

**Members and Staff:** Ernest Wick, LRT, Board Chair; Richard Fucillo, LRT, Vice Chair; Frank Erickson, MD, Radiologist; Carrie Whitlock, LRT, LRTT; Lorraine Bevacqua, LRT; Doug Cech, LRT; Peter-Jon Chin, CNMT, (Professional Imaging Member); Terry Lindsey, Manager, RPS (Advisory Member); Margaret Lut, RPS (Advisory Member); Linda Russell, Executive Director; Bernice Fox, Administrative LEDS Specialist; Heidi Park, Administrative Licensing Specialist.

**Members Absent:** None.

**Also Present:** Representative Mitch Greenlick, Chair of the House Committee on Healthcare; Michael Kaplan, Budget and Management Analyst, Salem; Brock Price, Assistant Director for Clinical Operations, OHSU; Susan Castanette, President-Elect of the Oregon Society of Radiologic Technologists; Amy Goodall, Oregon Medical Association; Shirlee Templeton, Oregon Institute of Technology; Lindi Quinn, Society of Diagnostic Medical Sonography; Pat Williams, Radiology Practitioner Assistant; Eileen Millsap, Epic Imaging; William Woodward, American Registry of Magnetic Resonance Imaging Technologists; James Madura, Chief Technologist, Adventist Medical Center; Claudia Black, Oregon Medical Association; Thomas King, President, Oregon Society of Radiologic Technologists; Deirdre Thompson, Nuclear Medicine Technologist.

### WELCOMING AND INTRODUCTIONS

Chair Ernest Wick welcomed everyone and called the public meeting to order at 9:16 AM in Conference Room 1B, Portland State Office Building (PSOB), Portland, OR for public input on how the Board will proceed with legislation for the 2009 session. Chair Wick stated the OBRT sent out 280 invitations to the meeting in an effort to reach out to all modalities and make this a success.

The goal is to craft new legislation that will accomplish oversight in accordance with SB144 and be respectful in establishing a common ground for all imaging modalities. After public comment, the Board and staff introduced themselves. Representative Greenlick stated that his committee stimulated where we are today. He said he was very much interested in making sure there was proper input from interested parties. He stated, "We will deal with this bill. This will be a relatively high priority for us to deal with in the next session, in one form or another. A lot of the comments we had was that we never had a chance to comment on it, from the sonographers as an example, and others. Here's your chance".

## **“LEGISLATIVE UPDATE” PRESENTATION – FRANK ERICKSON, M.D.**

Frank Erickson: I’m the radiologist on the Board. This is a special public session, to give you an idea of what’s been happening with the legislation that we’ve been asked to produce.

The OBRT was formed about 30 years ago. Just for background, at that time, the only medical imaging modality that was widely used was x-ray. The Board was tasked at that time to regulate the competence and conduct of the technologists who used x-ray equipment in order to protect the public from harm that was perceived to be there. It sort of goes back to the Buster Brown era when you measured your feet by looking at the bones of your foot and could x-ray yourself.

The Oregon Statutes and Administrative Rules governing the OBRT have not kept up with subsequent advances in imaging technology. They now include multiple modalities that weren’t foreseen at the time, and none of the operators of this new equipment are regulated or licensed in Oregon.

The current Board was asked to try to modernize the Statutes and Rules in order to provide oversight of the new operators, just as other health care providers are regulated in our state.

The following is a history of this effort to modernize. In the 2005 legislative session, there were routine budget hearings. In the Ways and Means Committee, a question came up as to why there were unregulated modalities of the imaging profession and why they had not been addressed. Senator Avel Gordly asked OBRT to address this issue of nonlicensure and report back in the next session.

So, discussion began amongst the Board members - why should we expand licensing, what are the benefits of licensure to operators? We identified what we considered public expectations that a healthcare worker is qualified and current in their field, that they can be depended upon to behave in a professional manner and that a mechanism exists to address concerns of misconduct or incompetence.

So, why the OBRT? It’s the case that OBRT has established standards for competence and conduct, and has a working mechanism for public protection that can be extended to all medical imaging modalities under one regulatory board, similar to the other boards; i.e., the Nursing Board with all their subspecialties and the physicians with all their subspecialties.

In the 2007 session, there were open public meetings in preparation – October 2005, January 2006, and March 2006. In April 2006, we got to the point of submitting the Legislative Concepts to legal and it was posted on our website. The Legislative Council voted and the concepts became the bill known as SB144 that was posted on our website.

To summarize SB144: There was a name change proposed that OBRT would become the OBMIT, the Oregon Board of Medical Imaging Technologists. It identified new modalities and proposed to expand oversight of the OBMIT to include all medical imaging modalities under one board. SB 144 became SB144A, passing the Senate with further amendments; the OMA thought we had to make it clear we weren't trying to add physicians. We changed the language just a little and it passed the Senate. Then it was stalled in committee in the House because there were concerns raised about the composition of the board, how we had planned it, the grandfathering details and other issues raised by members of the ARDMS, the SDMS – Texas and the OMA.

Representative Greenlick is here today as Chair of the House Healthcare Committee to encourage Board members to work out these concerns using public sessions to gather more information, build a consensus, rewrite this legislation and resubmit it for the 2009 session.

Here we've identified potential issues to be resolved – the major modalities and areas of subspecialty practice, specific standards and scopes of practice, refine grandfather procedures and testing, identify acceptable credentialing organizations, propose changes in Board composition, and talk about competency review/testing and specific legislative concepts for all modalities.

We identified other ideas we want to avoid that are obviously detrimental to healthcare practice in Oregon. We don't want multiple agency licenses for person working in more than one modality. In other words, if somebody wanted to be operating a PET scan and CT scan, we didn't want them to have to have two licenses. We didn't want to legislate anyone out of their job and we didn't want a decrease in availability of services in rural areas.

For today, we've invited you to make public comments on SB144A, to include any of these unresolved issues and allow us to reformulate the bill in time for the 2009 session. If we're successful, we expect to be able to protect the public from unqualified or unethical healthcare providers, to limit potential harm from diagnostic imaging devices and increase public confidence in medical imaging practitioners throughout Oregon.

## **PUBLIC WRITTEN RESPONSES TO NEW LEGISLATION**

Frank Erickson: That's the end of my presentation. I've been asked to read public comments from those who could not be here. This one is dated the 1<sup>st</sup> of November from Darryl Kaurin, Assistant Professor, Interim Chief Medical Physicist, at Oregon Health & Science University:

To whom it may concern:

Presently, we use a CT-Simulator for radiation therapy simulation, which is the case of most radiation oncology departments in Oregon. As with most radiation oncology departments, we have radiation therapists operate the CT with venter appropriate training. Radiation therapists coming out of radiation therapy programs are not usually RT certified (older RTT certificate programs required the therapists to be an RT to be admitted into the therapy programs, but this is no longer the case). We are operating under the guidelines that your organization suggested that a one or two day refresher course in CT is adequate for our therapists to operate the CT. I think this is appropriate. Please continue to push the legislature to provide guidance for this. We also have a PET/CT Simulator, along with one other radiation oncology department in Portland. Radiation therapy will be incorporating more functional imaging into radiation treatment plans, so this will become more common. For radiation therapy, there is a tremendous advantage to fuse the PET scan with the CT scan with the patient in the treatment position. The PET/CT scan with a radiation therapy table insert makes this practical, as the patient is set-up in the radiation treatment position and has both scans consecutively without the patient moving between scans. This allows us to map the tumor areas seen on PET to the CT with minimal spatial error. Most nuclear medicine technologists can operate the PET/CT for the PET portion of the scan along with a non-diagnostic quality CT scan to determine attenuation-corrections for the PET scan, but they are not CT certified and cannot carry out a CT for diagnostic use. The non-diagnostic CT is usually inadequate to use for treatment planning. I am arguing that our radiation therapists can operate the CT portion of the PET/CT scanner to obtain CT-Simulation information, just as described above for a normal CT-Simulation. Your attention to clarifying this issue would be appreciated.

This one is November 6th from Barbara J. Smith, MS, RT(R)(QM), FASRT, Instructor, Portland Community College:

Dear Board Members,

Thank you for inviting me to the public meeting on November 15 to discuss updating licensure for imaging professionals. Unfortunately, I have to teach at the time of the meeting so I am sending you my comments in this letter. Please include me in upcoming meetings and I would be happy to be part of any committee that may be set up on this topic.

Currently only radiologic technologists and radiation therapists are licensed in the state of Oregon. I believe that the board should work toward licensure of all imaging professionals. It makes sense to combine all imaging areas under the same umbrella, with a name change to the board to reflect the diversity of imaging modalities.

When adding the new modalities to the board a representative for each will also need to be added to the board. Perhaps that should be done with an eye toward the number of individuals to be licensed. Probably radiologic technologists will make up the largest number, but NM, MRI, and US will need to have representatives on the board.

People in the state of Oregon deserve to have qualified individuals perform their imaging exams. Right now, if there is a patient complaint in one of the imaging areas that is not licensed, there is not an easily identifiable body that can investigate this matter and deal with the individual. If someone is released from a job in one of these areas due to patient complaints, that person can get a job at another place since there is no way to regulate who is doing exams. The licensing board has investigators, and if needed, can revoke a license to prevent unethical individuals from practicing. Patient safety is why all imaging professionals need to be licensed, just as nurses are licensed, anyone who is in a position to deal with vulnerable patient populations should be licensed.

Thank you for looking into this matter and working for the inclusion of all imaging modalities in one licensing board. This will be a positive action for patient safety. I look forward to working with you on this matter.

The next one is from Robbyn Scriven, November 11th:

November 11, 2007 To the OBRT Board Thanks for the invite to the meeting on Nov 15th. I would love to be there as I feel very strongly about this issue. Unfortunately, staffing is such that I can't get the time off to attend. I feel that anyone receiving any kind of imaging should have the very best, most qualified individuals performing their studies. Under standardized governance, we could more accurately monitor the quality of the procedures and personnel practicing. As it stands now, there is little in place to regulate MRI, Ultrasound, and Nuclear Medicine individuals should there be complaints about unethical behavior or other issues related to imaging practice. The board will have to include an individual from each modality on the board for completeness. I do look forward to continued work with you on this matter.

The last one is from Bart Pierce:

I had planned to attend the meeting tomorrow but it is looking like I might miss it due to staffing issues. If I can't make it, know that I am in full support of licensing all imaging personnel.

## PUBLIC COMMENT

Chair Wick thanked Frank for his presentation and recognized Lorraine Bevacqua and Linda Russell for their contribution to the presentation to what has transpired with the OBRT over the last 30 years. He then asked for public comment on these or any issues. "We want to hear from the public - what the thoughts are, what is on your mind with regard to our discussion".

Shirlee Templeton: We also support the Bill. The issue that we're concerned about is that nuc med techs now sit for the ARRT for CT and Oregon's not letting them do diagnostic CT.

Eileen Millsap: I work for Epic Imaging in Portland. It's a free standing radiology clinic and I'm a nuclear medicine technologist. I'm supervisor of the PET/CT department and the nuclear medicine department and now the PEM department, Positron Emission Mammography, which is the newest modality that we will be dealing with. We currently have our nuclear medicine staff doing CT/PET scans and also have a CT or MR technologist present at the same time so we have somebody with the RT license. From my experience, I think the RT portion is not necessary and is an over step. Nuc med techs are well qualified to do the CT scans. On a 16-slice CT scanner, every scan is diagnostic. The difference between nuc med techs doing nondiagnostic will not exist in the future; the technology is so far advanced and that's on a 16. The next one coming out will be a 56, 256. In my department, we have the RT techs do the actual administration of contrast. That's a very simple thing to learn compared to the nuc med techs administering therapeutic doses that could kill somebody. Doing contrast is not a big stretch for them to learn. The other thing I think we should look at, if we're going to look at the long range planning for different modalities for tech's to do, is the next thing on the horizon, probably within the next 5 years. UC Davis is doing it for breast imaging. That's all I have to say for the moment.

Susan Castanette: I am the current President-elect of the Oregon Society of Radiologic Technologists, so I'm not just speaking for myself. This discussion has gone on at several recent board meetings. There already were some opinions voiced from Barbara Smith and Robbyn Scriven who also have been involved in these discussions but I just wanted to speak officially from the Oregon Society that we do also support this bill. When I was a new technologist, licensure had been in place in Oregon for a long time so I've never worked in a state where there was not licensure. But I have gone to Washington, DC with ASRT to lobby for the Care Bill twice and I'm very aware that there are a lot of states that do not have licensure, even for RT's. In those states, I've heard some horror stories; the physician training his wife to take x-rays and that may be perfectly fine in that state. I know there is a real need for national standards but I think for us to take our own step in the state and set higher standards is definitely showing that we are proactive and that we are trying to protect the public. When I hear arguments against this bill it's because I think technologists in their own mind don't want to have to pay another fee, they don't want to have to turn their CE into another licensing body. I know from working with the OBRT, and we work very closely with them and have a great collaboration, that they have made the process almost seamless, I know they have the best public interest at heart so I think we need to put aside our reluctance to pay another fee because I think it's very valuable to protect the public. I also think it makes us a step higher as professionals and that we should be willing to take that step to be licensed in all areas and to make all the imaging modalities that much more respectable in Oregon.

Bill Woodward: I'm an MRI technologist. I've been involved in the field for 18 years, both in a research capacity, actually before MRI was even an imaging modality in a research lab while I was in college, and then later as an MRI technologist in San Diego, I worked for General Electric Medical Systems as an MRI application specialist and later as a senior MRI application specialist for the 14 western states doing MRI. And before you think why did this guy get up and start talking all about himself, I really just wanted to frame the issue by now letting you know I am not a radiologic technologist and I have

no background in x-ray whatsoever. Not that I don't have a great deal of respect for the modality of all my dearest friends in the world who are x-ray technologists, radiological technologists. I wanted to take this opportunity while I was here to introduce to the Board and to the Chairman; introduce everyone to the American Registry of Magnetic Resonance Imaging Technologists, the ARMTRIT. This is a cover letter that describes a little bit about what we're about. We have been around, the ARMTRIT, for 16 years. We were the first certifying body for MRI technologists nationwide. We are a bona fide certifying agency. As people remember last year in Salem and listening to Representative Greenlick, he so eloquently stated that if the Oregon Board of Radiologic Technology, created in 1977, wishes to change its name and to encompass all of diagnostic imaging, I believe it's very important that they not only include other people on the board that do not come from an x-ray background, other imaging modalities, but most especially from other registries as well. Again, I have followed this on a national level for many years in the RadCare Bill. Even in the RadCare Bill, it specifically talks about each modality being independent and separate and that is new in the RadCare Bill. Previous versions of the RadCare Bill essentially would have encompassed everyone under the x-ray organizations and it makes perfect sense. These were earlier versions. I've followed it as of the last 3 years and it's kind of hard to follow the wording, deep in the RadCare Bill, but at least in the current version right now on a national basis, it talks about each modality being separate. I want to state, most especially for the public record, and everyone in here probably knows this, but just to get it on the record, MRI in terms of its physics, has nothing whatsoever to do with ionizing radiation. On a national level, there have been times where certain bodies have tried to press their political agenda and muddy the water with legislators who aren't as well informed as Representative Greenlick became informed last year. I also wanted to mention it wasn't just the ARDMS and the SDMS that had concerns and objections about SB144. We did as well. It's just that the ARDMS and the SDMS have a much larger representation in the state than we do. No ionizing radiation is being delivered with MRI. We're talking about magnetism and radiofrequency and they've used in national legislation with terms like thermal radiation to muddy the water so that legislators who have no background in medical imaging might be concerned into going along with the bill and bringing all imaging modalities under an organization nationally like the ARRT. Again, the ARRT, the national organization that most people on the Board belong to, has a need. For Pete's sake, when people are delivering ionizing radiation to patients that could harm them, they need to be licensed. Right now currently in Oregon, another issue that was brought up was that with this legislation they didn't want to put anybody out of a job. Right now in the state of Oregon, registry active members of the American Registry of MRI Technologists are working in mobile environments, small rural hospitals, the largest hospitals in the state of Oregon and the largest academic institutions in the state of Oregon, as staff technologists, lead technologists, and chief technologists. Even one of the board members in your hospital here in town, the new chief technologist in the MRI department is an ARMTRIT registry active member. The ARMTRIT is not exclusively for people who do not have an x-ray background. Many of the people in our organization are also ARRT and come from an x-ray background as technologists. It's not unusual for them to go into CT. Nuclear med is a little bit different for them but certainly, MRI is one of the things. On a national level, the ARRT has tried to address through making MRI a primary pathway in the next couple of years. Meaning, at one point there will be MRI specific schools that

individuals can go to, to get training specifically in MRI. As it is right now, SB 144 would have actually put many people out of jobs and it would have denied healthcare in rural areas in the state of Oregon. That being said, there's our introduction. If anyone wants to go online, it's ARMRIT. We hope that this process in Oregon will be an inclusive process rather than choosing to exclude people. Again, it's very important that this new board does not only have representatives from other modalities but other registries as well. Thank you very much for your time.

Rep. Mitch Greenlick: Mr. Chair, would it be appropriate for me to ask a question of Mr. Woodward. In your training, do you deal with any of the health effects of high doses of non-ionizing radiation?

Bill Woodward: Well, it's interesting, yes we do. As part of the examination process of the ARMRIT, the American Registry of MRI Technologists, you can heat a patient up. Currently what's happened is that over the 18 years that I've been involved in this, what the Food and Drug Administration – I want to try to make this concise but it's not very concise, Representative Greenlick. The bottom line is, delivering enough radiofrequency, which is what we're doing in MRI, all we're doing is exposing a patient to an extremely high magnetic field, which has no known side effects. We're then pulsing radiofrequency, not unlike the radiofrequency that's floating around in the atmosphere except it's at a very specific frequency, into the patient's body. Now at 3 Tesla scanners, which for many, many years...As a little background, 1.5 Tesla was always considered to be high field in MRI. As of the last 5 years, the first ones went in, up at the Oregon Health Sciences University, I believe about 4 years ago. I was there when that happened. Two 3 Tesla magnetic went in up there. You have to deliver more radiofrequency to the patients to achieve the same desired result and I'll leave it at that. For certain scans, T-1 for example, to have a little background in it, a factor of 4 x the RF. To answer your question, Representative Greenlick, it is possible to heat the patient up but the manufacturers as well as the FDA have addressed that issue. It used to be the old standard that you could not raise the patient's core temperature by 1 degree centigrade by pulsing radiofrequency into their body. So what happened is that the manufacturers of the MRI equipment are able to adjust the RF. Each manufacturer, having worked on all 3 of the big 3 manufacturers' equipment, handles this issue a little different. So, to answer your question again, I may be scanning a patient at 3 Tesla which is what I'm currently working on, and the scanner may give me an indication pop up message saying under these circumstances you're going to apply a little more radiofrequency again, just exactly like the radiofrequency that's floating around in the atmosphere.

Rep. Mitch Greenlick: If I can follow-up. The issue with radiofrequency floating in the air is that the potency of it disappears at the rate of the cube root of the distance from the source, if I remember that correctly. The notion we have radiofrequency floating in the air isn't the same as the radiofrequency directly at the patient level.

Bill Woodward: Very true, Representative Greenlick. To also frame it in a little clearer, the radiofrequency that we're pumping in is at a very specific frequency. It's a long story on that one, but there are no known effects from pulsing radiofrequency into someone. It is handled by each manufacturer. It is impossible to pump so much in.

There has never been a case where an individual has been harmed by the radiofrequency being introduced by an MRI.

Frank Erickson: I have to comment. It's not just radiofrequency. There are many, many safety issues in MRI that you're not going into. There have been deaths with MRI machines.

Bill Woodward: Regarding what?

Frank Erickson: Specific accidents. Training difficulties. There are many scenarios related to training.

Bill Woodward: With training of?

Frank Erickson: The technologists and the ancillary staff of the hospital. There are other things not to ignore that we can't license.

Bill Woodward: But it's also very important, since you mentioned that, every accident that has occurred in MRI, or the vast majority of them that are categorized, are by ancillary personnel and that's why MRI technologists are taught...

Frank Erickson: I have to disagree. It has been my experience as an MRI radiologist...

Bill Woodward: Where at, Sir?

Frank Erickson: There are ways of damaging patients, following all the rules and have a perfectly functioning MRI machine simply because of the physics of the coil, part of the surface of the coil

Bill Woodward: Well, there have been burns that have occurred. I'm aware of that, too. But radiofrequency specific is what I thought...

Frank Erickson: No, restricted to the radiofrequency, that's not the only issue.

Chair Wick: Let me interject here. We've spent a lot of time on this alone and today's efforts are here for input and concerns. Let's give everybody else a chance to talk. Thank you.

Brock Price: I'm the Assistant Director for Clinical Operations at Oregon Health Sciences University. I'm glad to have the opportunity to comment. I've enjoyed participating with the Society for Nuclear Medicine in Washington, D.C. this past summer to visit our two state senators' offices, Gordon Smith and Ron Wyden to help promote the bill. We've been working with the OBRT and Radiation Protective Services to help our staff keep up. I just want to comment on training. When I was with other representatives in Washington, DC I found out so many other states don't have licensure but when you hear the number of states that do have licensure, it really makes sense that Oregon really needs to be on the same page with the rest of the country. The direction we're going is outstanding. There are competencies that are in place with

ASRT and the Society for Nuclear Medicine that do cross-training. We had some relative success with that at various facilities in the state already and if we can keep that momentum, I support the direction you're going. One thing the Board needs to consider with the accreditation is the certifying bodies. There should be consultations with hospital administrations to understand about the complexities of hospital reimbursement because we're under pressure as well as anyone else. Reimbursement is also based on registered technologists, and each year it comes up. Last year it came up with making sure we have full accreditation of 1 or 2 national accreditation bodies in order to get reimbursement and that will impact in what direction we will go.

Chair Wick: Thank you very much.

Claudia Black: My understanding is you're going to hold a series of meetings and that this is one of several opportunities for input – is that correct?

Chair Wick: That is correct –this is the beginning.

Lindi: Have the meeting dates been set?

Linda Russell: We have some tentative dates.

Chair Wick: We will post all the meetings on the website as well as meeting dates and times as they evolve. For the record, the next meeting will be December 14 in this meeting room at 6:30 PM and as we move forward in this process, if we need to have more or less, we will juggle that schedule. We are also on a schedule with the legislators as far as what we have to do as far as that process goes. Some of the meeting dates and processes are actually beyond our control and we try to fit them around everybody's schedule as well.

Eileen Millsap: I just wanted to take this opportunity to comment that I do strongly support licensing of technologists in nuclear medicine, MR and ultrasound, all modalities that aren't currently licensed. I think the problem we're going to have in the community is that with all of our cross modalities, we're really going to get into a lot of trouble where you have modalities that are not certified. So I think we need to look at cross-training. We need to make cross-training doable, either with training by manufacturers or through CEU's for each of our technologists. For example, our nuclear medicine technologists, sit for the CT boards and sit for the MR boards. What's going to happen is that you are going to have really limited imaging because the state won't be able to stay up with the technology that's going to be out there and so they will become sedentary. So what we need to look at is getting our techs licensed, along with other challenges.

Chair Wick: If there anyone else out there, at this point in time, would you come forward and offer comments?

Jim Madura: I'm the chief technologist at Adventist Medical Center, Nuclear Medicine. I've worked in a number of states throughout the country. I'm from New York originally. I've been in Florida, Maine, Arizona, and Colorado. Some states have licensing, some do not. I find that most states that do have state licensing do not require anything other

than you waving your NMTCB certification in front of them and sending them a check and you're suddenly state licensed. What other qualifications are you going to require on the Oregon state licensing if this goes through that says I'm qualified to work in this state because as of now, I'm qualified to work in any state in the country. So, other than sending in a check, what are you going to require of the technologists to prove that you are worthy of state licensing? I agree with what Eileen is saying that cross-training is very important. I have done some cross-training through a company, MIC, you may have heard of it, they are out of New Jersey. Basically, as a nuc med tech to become CT certified, what you have to do is at-home training with 6 modules, take your test and then sit somewhere in the CT department where they will allow you to assist in 125 scans, broken down by different body portions and just get signed off. Once you have those 125 scans plus your 6 modules that you've sent in, you can sit for the CT board with the ARRT. So, other than that, I don't know what other cross-training programs are out there and that's pretty straightforward. As Mr. Woodward was saying, I have great respect as well for all the other modalities that we have. I also know many, many technologists throughout the industry. From my experience, they all have their difficulties, they all have their inherent dangers to patients. I'm least knowledgeable about MRI, that's very interesting. I'd like to look more into that. CT obviously has high energy, high radiation, it can be very dangerous. Nuclear medicine is simply injecting radio-pharmaceuticals into patients. As you pointed out, it's very easy to harm somebody, especially with therapeutic studies. Anyway, what I'm interested in, is there going to be some other kind of qualification for technologists to get state licensing other than saying I'm federally licensed?

Frank Erickson: What do you propose? What would like to see as a requirement?

Jim Madura: That's a good question. I don't know.

Frank Erickson: Is CME documentation enough or do you want to have us give you a test?

Jim Madura: My questions are not too clear on it. If you sat for your federal test, which is rather involved, not so easy, what is the point of being licensed by the state? It's interesting to be state licensed wherever you go. When I worked in Colorado when I was fairly fresh out of school, I was kind of surprised there was no state license thinking that was the norm. Over the years, I questioned it. I have NMTCB backing. What does Oregon backing or Colorado backing mean? What is the difference? Why should I have it? I don't know.

Carrie Whitlock: If I could explain the difference between certification and licensure. Certification is when you go to our registering bodies, ARRT, SDMS, things like that and we take our tests. That says we've met the educational requirements and we are academically competent to perform these things. That's one piece, that's not licensure, that's giving us our credentials. Licensure, like what we do here on the OBRT, is saying that for anyone who wants to practice within our state, that's x-ray or therapy right now, you also have to meet other things, which aren't competencies; they are ethical, professional conduct. Here's an example. If I am credentialed and I'm licensed, if I do something to a patient or if I perform something that I'm found guilty of as unethical, I

will lose my credentials and I will also lose my state licensure, which means I can't practice. If I have credentials and I do not have a license and I do the same act that is unethical and found guilty of it, I can lose my credentials and I can still practice because there's no authority saying that on a state level, you have been found guilty of this and you can no longer practice. That's a huge difference between certification and licensure that you can lose your certification, you're unlicensed, you are still allowed to practice.

Frank Erickson: There's something I left out of the presentation is that 80% of the cases that we discuss in the Board that are brought to us as complaints, 8 out of 10, are for conduct, nothing to do with the modality, the safety or competence, it's conduct. So, this turns into a grand jury session, if you've ever been on jury duty.

Eileen Millsap: I just want to make a point of clarification. For the nuclear medicine technology boards, starting this year you need continuing education units so there is some ongoing training that goes with that. We were already doing it on our own.

Shirlee Templeton: We have incorporated CT classes, cross-sectional anatomy into our nuclear medicine program at OIT and we will continue to do that. We have a CT simulator and an MR simulator also. We're trying to keep up with it.

Chair Wick: This is great information for us to hear and the Board will continue to take in a lot of information in between meetings as far as communication with anyone of us as well as Linda. Like I said earlier, we sent out 280 invitations, I suspect that we will receive dialogue from the public in this process. I see some people coming in late. Do any of you wish to come forward? Come on up here Tom.

Thomas King: I'm president of the Oregon Society of Radiologic Technologists. I just came from an eye appointment and I'm very happy I can see you all. Unfortunately, I wasn't here for the earlier testimony but as an acting member for the society and keeping up with various stakeholders, including the Oregon Board of Radiologic Technologists during the last legislative season, it became very apparent that we needed changes to ensure that Oregon citizens get quality care and that the people taking care of them really should be out there taking care of them. The other side that I can see apparent is that it is incumbent upon us as professional societies that we attempt to work together with all folks who are taking care of the public. To that end, our societies may make a commitment that we reach out to all modalities to see if we can find common ground. That being said, we have to look at the greater good. At the current standing now, are Oregonians being adequately protected? Well, for a vast majority of people out there who've decided to go into healthcare, yes, they're there because they want to take good care of patients. But there is an element and as maybe the folks on our Board can testify, increasingly so, there is an element there that really shouldn't be out there taking care of patients. And to that end, I urge the legislators and all stakeholders to take a look seriously that we work together and find some sort of legislative consensus to bring a form of licensure that will not hinder development and professionalism of the folks who practice imaging or therapy in a proper manner but give us an adequate method to weed out those that shouldn't be there. As technology moves forward, I think what really distresses me here is it takes a couple of legislative seasons, to keep things moving along. Unfortunately, the technology is moving way

faster than that. So, it would be nice to get this as a ground floor opportunity to get a presence here, get a consensus, get some needed legislative change and I think in the future we can probably move on and keep up with the technology in real time. That's all I have to say. Thanks.

Susan Castanette: I really just have a question because I'm reading the background information that Linda sent me. The original opposition to this mostly came from sonographers and I haven't heard from any sonographers today. I'm wondering, has that been resolved, has there been any communication between the last House session and now or do we just have no comment from the sonography field?

Chair Wick: To answer your question, we have issued an invitation to attend this meeting and future meetings. Whether they choose to come forward at this time or in the future, it's up to them. But we've included them in our invitations and Linda and I have had some one-on-one with some folks also. So, we're anticipating comments from all modalities and we've invited all the modalities. And we've also included a whole bunch of other folks in the different modalities besides the associations – hospital associations, Board of Medical Examiners, Board of Nursing, a whole variety of folks. 280 invitations went out and a lot of that list came from people who attended the meetings in Salem. We got input from the legislators who they thought ought to be there attending our meetings. We solicited information from our individual employment places as far as to what their thoughts were and got their feedback. A lot of people were invited.

Lindi Quinn: I'm a registered diagnostic medical sonographer with specialties in OB/Gyn, abdomen and vascular technology and I've been practicing in the state of Oregon for 20+ years. I am currently the Treasurer for the Society of Diagnostic Medical Sonographers and I'm here today as an observer on behalf of the society, an observer. I'm sure there will be correspondence and I don't think the issues have changed and the concerns since last Fall or was it Spring? They are still our concerns. A lot of our energies on a society level right now are human and financially going towards the Care bill, which I know a lot of you are familiar with. There has been a lot of collaboration with all of the medical imaging groups throughout the country and that bill is moving forward. It takes a lot of resources and so that's our focus right now but I know that on December 14 there will be others here to speak on the issues.

Lorraine Bevacqua: For the record, would you care to state what your issues are?

Lindi Quinn: Well, I think they are on record with the correspondence that was sent before. We have issues with the grandfathering provision. We have concerns over the credentialing details and how we feel strongly as a professional organization, that credentialing should be tied to any form of licensure or reimbursement and credentialing by specialty. There are a lot of sonographers who may be ARDMS credentialed but if they are doing abdomen and OB/Gyn and they're only credentialed in abdomen, then they're not providing the best care to that patient which I think is everyone's main concern here. Incompetency exists everywhere and I believe that incompetency is a greater issue in the medical community than the background checks. Not to say that they aren't an issue but incompetency and lack of appropriate credentialing. As a

sonographer, I believe in cross-training. I've seen it in my profession. I was an RT before I was cross-trained in a diploma program but once a person is cross-trained, they need to prove competency by becoming credentialed. Every other medical professional is expected to be credentialed. I cannot say the word credentialed enough. It's critical to patient care.

Chair Wick: Thanks Lindi. I think that just about everybody from the public has spoken. Is there anyone who hasn't?

Pat Williams: I'm an RPA who works at St. Vincent's. I'm just here to represent any other of the other RPA's in the state, there are seven of us currently. The only concern we have is that it is listed as an RPA as a radiology physician's assistant and it is not. It's a radiology practitioner assistant. That's the only concern because we are already all registered technologists.

Frank: All of you are RT's first?

Pat: Yes, we have to be RT's with at least, when I went through school it was 5 years. I think now it is seven years.

Frank: State what RPA is again, for me.

Pat: Radiology practitioner assistant. That's all I have.

Chair Wick: Thank you very much.

Peter: Is there such a thing as a radiology physician's assistant?

Pat: No. Not that I know of. They're all certified by the CBRPA.

Terry Lindsey: I'm with the Oregon Radiation Protection Services. One of the things that was a main concern early on in the RPA program at Weaver State in Colorado where a lot of the graduates came out of, is that the first terminology was radiology physician's assistant and then it was clarified later on because there were concerns about that issue in terms of name, and this name came about later

Pat: I think it was in 1996.

Terry: So, there was some confusion in terms of the name early on and there were concerns in terms of physician's assistant in that you're making a claim to be a physician's assistant versus practitioner and I think that clarification is helpful.

Pat: Yes, hopefully, 11 years later.

Chair Wick: I really appreciate it, as the Board does, the input from you folks. We're looking forward to this process. Are there any other comments, questions or concerns from the public?

Linda Russell: I just have one concern. If you could let me know you'll be coming so that when we set the room up, we could set it up smaller and all of us could be up closer. I had no idea how many people would be here today and it was very difficult. I got very few RSVP's, so if you could just kindly let us know, even to OBRT Info. Go to the website, send something, and let us know. Pick up the phone and just leave a message if you don't get a person. We would greatly appreciate it. It would make this whole setup much easier.

## ADJOURNMENT

The meeting was adjourned at 10:25 AM. In an effort for the Board to reach all of its interested parties, they will hold an evening public meeting to discuss future legislation for the 2009 session, on December 14, 2007 at 6:30 PM in Conference Room 1B. The Board will hold meetings in January and February 2008, weather permitting. The OBRT will accept any written comment concerning future legislation until the end of February, 2008. If parties are unable to attend any of the upcoming meetings, please contact Linda Russell at [linda.russell@state.or.us](mailto:linda.russell@state.or.us) or you can access a link from the Board's website at [www.oregon.gov/RadTech](http://www.oregon.gov/RadTech), under "Contact Us" or e-mail us directly at [OBRT.Info@state.or.us](mailto:OBRT.Info@state.or.us).