ADVISORY COUNCIL ON RADIATION PROTECTION

BUREAU OF RADIATION CONTROL

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ADVISORY
COUNCIL ON
RADIATION PROTECTION

CERTIFIED
TRANSCRIPT

Bureau of Radiation Control

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Reported by
Rita G. Meyer, RDR, CRR, CRC
Realtime Reporter and Notary Public
State of Florida at Large

ADVISORY COUNCIL MEMBERS PRESENT:

Randy Schenkman, M.D., Retired (Chairman)
Mark S. Seddon, M.P., DABR, DABMP (Vice-Chairman)
Kathleen Drotar, Ph.D., M.Ed., RT. (R)(N)(T)
Albert Tineo, MS, CNMT
Rebecca McFadden, RT(R)
Matthew Walser, PA-C, ATC
Nicholas Plaxton, M.D.
Adam Weaver, MS, CHP

FLORIDA DEPARTMENT OF HEALTH STAFF

Cynthia Becker, Bureau of Radiation Control
James Futch, Bureau of Radiation Control
Brenda Andrews, Bureau of Radiation Control
Kevin Kunder, Bureau of Radiation Control
Clark Eldredge, Bureau of Radiation Control

AGENDA

MORNING SESSION

AFTERNOON SESSION

RANDY SCHENKMAN, CHAIRPERSON: So this is our October 8th, 2019 meeting. And I thought even though we don't really have anybody new, it wouldn't hurt for everybody to go around and reintroduce themselves so everybody knows who's who, so I'll start.

I'm Dr. Randy Schenkman. I am a retired radiologist. My specialty is women's imaging and breast imaging in Miami at Baptist Health System.

MARK SEDDON: I am Mark Seddon. I'm a diagnostic medical physicist. And I'm the RSO and chief physicist for the Advent Hospital systems in the north and southeast regions of Florida.

KEVIN KUNDER: I'm Kevin Kunder. I'm with the Bureau of Radiation Control. I'm the radioactive materials administrator.

KATHLEEN DROTAR, Ph.D.: I'm Dr. Kathy Drotar. I'm the radiation therapy board member and program director for radiology at Keiser University and also vice-president of the Florida Society of Radiologic Technologists.

ADAM WEAVER: I'm Adam Weaver, University of South Florida in Tampa. I'm a radiation safety and laser safety officer.

NICHOLAS PLAXTON, M.D.: I'm Nicholas Plaxton.

I'm a nuclear medicine physician over at Bay Pines.

MATTHEW WALSER: I'm Matt Walser. I'm a physician assistant up in Gainesville at UF Health and I don't do anything with radiation.

REBECCA McFADDEN: I'm Becky McFadden. I'm from Advent Health Ocala. I'm the non-invasive radiology manager currently but I am sitting on the counsel as the radiologist technologist position and I still interact with a lot of the schools in radiology even though my specialty is cardiology these days, which has recently changed.

ALBERTO TINEO: I'm Alberto Tineo from Halifax Health in Daytona Beach.

CLARK ELDREDGE: Clark Eldredge, Florida Department of Health, Bureau of Radiation Control, radiation machine administrator.

BRENDA ANDREWS: Brenda Andrews with Bureau of Radiation Control.

CYNTHIA BECKER: Hi. Cindy Becker, Bureau of Radiation Control.

JAMES FUTCH: And James Futch, administrator of the technology section, Bureau of Radiation Control.

RANDY SCHENKMAN, CHAIRPERSON: Okay. So welcome.

We have to approve our minutes from May 23rd of

2019. Does anyone have any questions, comments?

BRENDA ANDREWS: We did make a few changes. Kathy Drotar sent a couple things in for us to change, which they were made, and there were a few name changes or corrections and some terminology corrections, acronym corrections and all of those were made.

RANDY SCHENKMAN, CHAIRPERSON: Okay. So were there any other comments? Was that all?

KATHLEEN DROTAR, Ph.D.: That was all, yes, it was. Thank you.

RANDY SCHENKMAN, CHAIRPERSON: Okay. So we'll make a motion. All in favor of approval, say aye.

COUNCIL MEMBERS: Aye.

RANDY SCHENKMAN, CHAIRPERSON: Any opposed?

(No Response)

RANDY SCHENKMAN, CHAIRPERSON: So passes unanimously. Okay.

Now Cindy, it's your bureau updates.

CYNTHIA BECKER: Okay. I talked with a few of as you came in today, but I was going to talk a little bit about our staff -- our current staff and our new staff.

Our vacancies, we have seven new staff within the last six months. So we've been on a roll right

now to fill positions. We do have a full field inspection staff now.

Johnny Frazier is with the radiation machine section. He was newly hired. So he's helping out with the 18,000, maybe 19,000 plus registrations that are coming in this time of year. They have a full staff now. Yay. We even have a contract person helping out through December.

Terry Hague. I didn't know if you were going to mention him, but he's our new IT person that was hired working with James and Brad and Nina. So that's been very helpful.

Kevin, we've got you on the list, but you did start in April, so he came to the last meeting in May.

Chris Wallace, he is an inspector that is in the Tampa area. Chris -- Miami area. So whoever's in Miami may see him.

Andson Harrison. Andson is in Tampa. He's a newly hired inspector and as well as Carmen Hernandez in Tampa.

And then Hilda Anaya, she's a staff assistant that is actually working for the central office, but she is located at our lab in Orlando. So that's our newest staff in the last six months.

We still have five vacancies, three of which are in the lab section for John Williamson. So wish him luck in filling those. We have one in the materials section and we have one that we're trying to figure out what to do with, I guess at the moment, but it's been vacant for a little while. So that's kind of our five vacancies for our staff.

We have travel restrictions going on through October 27th. So we're here because this is statutorily required that we meet at least twice a year. So you're lucky enough to be here.

The Health Physics Society Florida Chapter meeting will be a little bit slim this year with our attendance. Usually we have five to ten people attending that and this year, it might only be James attending. So you have to represent us well.

JAMES FUTCH: Save all your questions and I'll answer all of them.

CYNTHIA BECKER: Represent us well.

JAMES FUTCH: I might still have a job.

CYNTHIA BECKER: So in the last six months since we met, we had our integrated materials evaluation program evaluation, how it's IMPEP'D. We were IMPEP'D. The evaluation audit that's done every four years by the NRC. They have oversight of

our program, just like we have oversight of licensing programs that -- around the state. They have oversight of ours.

So they spent a couple weeks with 14 of our inspectors out in the field. That was in April and May. And then in June, the last week of June, they spent a week up in Tallahassee going over our licensing files, interviewing staff, looking at our training records. Adam knows the drill from being in Tampa before. He probably got accompanied before.

So it was a very extremely thorough audit. I don't recall ever having one like that before. It was a very good team that they had put together. And a few things they uncovered for us, which really actually helped us.

As you know, we had a turnover of some critical staff within the last couple years. And I think really because of that and because of all the other things happening, we didn't really keep up with Part 37 changes as we should have. So they noticed that we did have some knowledge gaps in that area. And we implemented some new procedures. We did some extensive training. Thanks to our fellow help here from Mark Seddon and folks at his facility, we did a

lot of training after they left.

And with that, I think we're now more up to speed with where we need to be. It doesn't stop, of course. We're continuing the training. We took a lot of our staff out to some facilities and -- both in Tallahassee and down in Orlando and we were lucky enough to observe, ask a lot of questions, get some demonstrations about what physical security measures should be in place for some of our high-risk licensees like gamma knife and dust radiography; that sort of thing, so I think we're on our way now to kind of enhance some of our training and our procedures that needed to be enhanced.

That was one of the things that they picked up on. The other thing was compatibility requirements and that has to do with we have to maintain compatibility with the Nuclear Regulatory Commission. When they implement rules, we have to be consistent with the adoption of our rules and have to be timely within three years. And we were behind on some of that as well.

So Kevin and I went up to DC and expressed how we had started really implementing some of these changes and I think it went well. And I think he's going to talk a little bit about where we are with

the trying to adopt some of those rules. At least we got language put together. But he's going to talk a little bit about the compatibility part. So we're kind of tag teaming.

That's kind of all the updates I have. Unless you guys have any questions for me about staffing or what's going on in our bureau, that's what we're here to talk about. But that kind of took over our world for the last six months.

RANDY SCHENKMAN, CHAIRPERSON: Do you have candidates that you're thinking about for the staffing?

CYNTHIA BECKER: For the staffing, Reno -- poor Reno. Reno has picked out several different really highly qualified staff and he would get them right to the point of accepting the job, and then they would say, never mind. I've gotten another job. Usually for more money. I know, it's sad. So that, that was about three times he's had that happen. But he does have some staff in mind for his position.

BRENDA ANDREWS: John does, too --

CYNTHIA BECKER: Yes, John does, too.

BRENDA ANDREWS: -- for the manager. We have one that's moving through the system pretty well

right now. A lady from Texas for one of his manager positions.

CYNTHIA BECKER: Yes, she looks highly qualified.

BRENDA ANDREWS: She's very highly qualified.

CYNTHIA BECKER: That would be good. As you know, it takes the State some time to get through the system, hiring system and I hate that part because you're waiting for somebody to start, you're waiting for somebody to start, and so --

BRENDA ANDREWS: Mm-hmm.

CYNTHIA BECKER: Hopefully that will go through.

MARK SEDDON: Are there any critical openings that are potentially affecting your guy's ability to maintain, keep up with IMPEP?

CYNTHIA BECKER: No, because all the inspection field staff are now filled and they've actually been trained and are out there starting to do inspections. So that is good. Also, the materials staff is well on their way. They only have the one vacancy now that's going to be the end of October when Joe retires. So I think we're, we're good in that area. Yeah. So I guess I'm passing it to Kevin now.

KEVIN KUNDER: Just an overview of the rule changes. Why we fell behind was I guess because of Governor Rick Scott, when he came in, on his first day, he signed Executive Order 11-01 and it was titled Suspending Rulemaking and Establishing the Office of Fiscal Accountability and Regulations Reform or OFAR. So we kind of fell behind with doing some of the rule developments that came down.

As Cindy mentioned, we jumped on things right away when we found out that we were behind and the end of June, we submitted some things and gotten those things back already from the NRC. We got everything else in by the time that Cindy and I went up to DC, so that would've been the second week of in September. So we had everything in for the first run of the stuff to the NRC.

Some examples, some of the changes for medical training and education, which is removing the compatibility statement and adding if they're Board certified, they do not need attestation. So we're working on that. Yet another medical was adding and defining some that we haven't had before, but they're calling it Associate RSO. We have an Associate RSO on the license as well.

Nuclear pharmacy, they're expanding some of the

compatibilities with that. They're looking at our existing licenses with the nuclear pharmacies, there was no, no effect on the existing licensees.

Source material exemptions, for general license source materials written, regs are being written to be more compatible and adding requirements to be able to distribute.

Industrial radiography, there was just some definition changes for temporary location and mailing address changes we had to make and then source and device registry, basically just some updates for compatibility with the NRC guidance documents. And I think the only difference between what they have and what we're going to have is ours is going to be specific to Florida.

So that's some of the stuff that we're working on. We're just waiting to get that stuff back from the NRC and continue with that.

For materials, we had two medical events since the last time we were here. One was an HDR using a SAVI system. It was a week long, two times a day, five days. And on the third, third or fourth treatment, they went ahead and the physicist had started the procedure and when it was sending in the source to check the resistance and stuff, it popped

up and said it had some resistance and said, do you want to abort or continue? And the physicist just hit the abort. So it took it out altogether, so it took the treatment plan out of the system altogether. And then he brought back in the next patient, which was the top on the list. The patient was familiar with him because he's already dosed that patient. And it ended up being, the SAVI was for the breast. The next patient was a vaginal. So they went and started that and he was in the room waiting for it to transfer and decided it wasn't transferring and stopped it right there.

So the patient was supposed to get 3400 cGy for the whole treatment and the individual ones were supposed to be 340 cGy and they received 680. So they ended up just doing one less fraction for that.

The second medical event was TheraSphere. And it was a patient having to follow-up treatment a year later. Right lobe of liver had been treated the year prior and this time, it was a kind of in between segment of the right lobe. So they went in and they had prescribed 300 GBq dose, which meant, if you guys, I don't know if you're familiar with nuclear medicine, we draw up a dose. We order a dose in for what we're going to use at that time.

For this TheraSphere, they order from the manufacturer a higher dose, and they look at for it to be decayed down by the time you use it to the dose they want to use.

So they ended up giving -- grabbing another dose for a patient later in the week that was a higher instead of 3 GBq ordered dose, it was a 5 GBq ordered dose. So the patient ended up, instead of getting 120 Gy, they got 678 Gy. So those were the two medical events.

And then I think as Cindy mentioned, as far as my staffing goes in materials, when Joy Stevenson took my consultant position, it left an evaluator position open. Lynn Andresen, who's been in the technology section, she moved over on Friday to my section. And she's going to start doing -- being another evaluator of mine. She's in training right now, so it fills that position that was open last time.

And as Cindy was mentioning, I'm going to be losing -- Joe is going to be retiring, Joe Major is going to be retiring. He does the inspection reviews for license -- for the materials section. And he'll leave the end of this month. So I have that position open. It's still open for another

week out there if anybody knows anybody. But that's -- those are my openings. Medical events and -- does anybody have any questions?

REBECCA McFADDEN: Is your opening in Tallahassee?

KEVIN KUNDER: Yes, it is.

MARK SEDDON: For the TheraSpheres, have you guys done the investigation yet?

KEVIN KUNDER: Yes. Yes.

MARK SEDDON: Have you made recommendations to them?

KEVIN KUNDER: Yes.

MARK SEDDON: Do you want to follow-up? There should be a time out treatment, time out for the treatment with the interventional group to verify the dose?

KEVIN KUNDER: They are doing commission sites. They should have been doing that.

MARK SEDDON: Yeah, because what happens, they do -- for joint, they do that for the patient, and for the interventional part, but they also --

KEVIN KUNDER: When the new person comes in the room and they bring new doses, they go through that again.

MARK SEDDON: Right.

KEVIN KUNDER: We're doing that, too.

NICHOLAS PLAXTON, M.D.: When that dose showed up in the department, I mean, they should be measuring what the dose is. They should have known because it's a week difference you're saying?

KEVIN KUNDER: It was -- I don't know how much detail to go into because it's still active. We're still working through.

CYNTHIA BECKER: It's fine.

KEVIN KUNDER: But the RSO nuclear medicine technologist, in his mind, because again, it's a difference between, you know, I call the nuclear pharmacy, I order 20 military bone dose and I look and I throw it in the dose caliber, it's 20 mCi, I'm good to go. This one, if I need, like on this one here, they needed a .3 GBq. I had to order -- that was on a Tuesday. So the prior Sunday -- not that Sunday, but the prior Sunday before, I had to order a 3 GBq dose so it decays down to that.

So what he was doing is he was looking at the --

NICHOLAS PLAXTON, M.D.: Sure.

KEVIN KUNDER: -- the dose that was in the dose calibrator, which is now three. He's looking at the order instead of the prescribed dose. So he did

measure that morning when they said, okay, I've got a patient here. Can we start? Do we have a dose? He measured it. And then just prior to them bringing it over to the interventional lab, measured it again. But that's in his mind, he was looking at that.

NICHOLAS PLAXTON, M.D.: I see. Got it.

MARK SEDDON: The other trick with TheraSphere is a lot of time they hand write everything out in the nuclear medicine lab without doing the calculation in a spreadsheet.

So you also want them to make sure they enter the date in a spreadsheet so it calculates out and flags them beforehand so that when the authorized user signs off on that spreadsheet before they dose a patient, that would've been caught with the doctor.

NICHOLAS PLAXTON, M.D.: That's what we do. We do the spreadsheet. It is a lot of hand calculations.

MARK SEDDON: Yeah, it's a lot of hand calculations but then you --

NICHOLAS PLAXTON, M.D.: You want a spreadsheet to catch it.

MARK SEDDON: Because they're not using --

nuclear medicine techs aren't using GBq, unit changes, it's kind of foreign to them a little bit. These are just some recommendations.

KEVIN KUNDER: All right. Thank you.

RANDY SCHENKMAN, CHAIRPERSON: Okay. Now we turn it over to James.

JAMES FUTCH: All right. So in this little section, we would normally have Gail Curry or one of her staff. They've had some staff out for quite a bit and are doing some catch up. So they forwarded some things to me to provide to for this today for MqA.

So as they often do, we start out with numbers. And MqA, of course, at the program office is focused on the licensing of technologists. So they usually give us a current total. So right now there are numbers as you see them on the screen. 22,500 plus radiographers, 2500 plus nuclear med techs, radiation therapists, a little under 2,000 and radiologist assistants, current clear and active, 32.

I think looking at the license numbers, at one point, the license numbers were up to like 114. So the balance of the radiologist assistants have, I guess, expired and not been renewed. There's about

32 activate at the moment.

They didn't give all the different kinds of techs. The computer tomographers, 545 clear and active. There's also a fair number of mammographers that didn't make it into the list and basic machine operators, just over 2,000.

And the total is 28,383 clear and active licenses. And that number varies whether or not you're talking about licenses or actual people because people can hold multiple licenses.

If they have a completed application, which to them means that it's come in, it's got all of its paperwork, it's got all of its money, there's nothing wrong in the system preventing that particular application being processed, they get it done in less than a day is their average statistics. Of course, the long period of time is getting all of the documents needed to make the application complete and bring it all together so the staff can act on it. But this is a reflection of how fast they get to it if it actually comes in that way from the very beginning.

And they're up to date on their backlog. It looks like they only have six applications as of today that aren't being worked, which is tremendous,

because at one point there were many, many folks backlogged and they've done a really good job of catching up with all of that.

So that's the MqA update.

ALBERT TINEO: Any reason why the radiology assistants are not renewed?

JAMES FUTCH: I'm not really sure.

ALBERT TINEO: Is it jobs or is it --

JAMES FUTCH: We had a discussion last meeting from Christen Crane-Amores, who is the radiologist assistant on the council. And she -- I think she had spoke to, I forget exactly what she had brought up about that. But it's always been, this profession was created around 2008 in Florida, if I remember right. And it's never, it's never been more than 100, I think, licensees. And I think maybe --

KATHLEEN DROTAR, Ph.D.: I can add to that. One of the reasons is because CMS, in its infinite wisdom, had blocked or had stated that a radiologist had to be present in the room. And so there are a couple bills in Congress to try and get that unbundled so that the radiologic assistants can then function as they've been trained to do. And so I can get those bill numbers for you to and send that.

But what happens is, when Sarasota Memorial, which is like one of the third largest in the state, and they don't hire RAs because the radiologist has to be there. And they can do more with a PA not in the radiology department, but because they can see more patients. It's not cost effective for them to do that. And then you also need to have a radiologist who is willing to have that person working with them, too. I don't think that that's so much an issue.

But that the positions aren't there because of the way their reimbursement falls out. They have not been able to do the job that they've been trained to do and are certified to do. But Florida also has the largest number of radiologist assistants in the states, so -- yeah.

JAMES FUTCH: Okay. We -- there was a bit of discussion about that after Chris's talk last time, so I went out and looked at our current practice standard, which is role delineation, and the current one that ASRT has out there and also the ARRT entry-level clinical activities document and I've done a little bit of an update about that in the technology section, which is scheduled for, I think 2 o'clock this afternoon. So we'll come back to

that.

ALBERT TINEO: Okay.

JAMES FUTCH: There were, while I'm on the subject of MqA updates, there were two other issues that came up at the last meeting which MqA was involved with.

Chantel had brought up an issue that some of her members who, NMTCB has the relatively new certification. And we had changed our regulation last year to allow a person with that credential to apply for the Florida CT license by endorsement. We've had the ARRT pathway for a number of years now. And she reported that there was some difficulty with her association members saying they couldn't apply online and asked us to look into it.

So MqA went back and talked to their IT folks. I went back and talked to our IT folks and have a little bit of an update to show about that one issue.

So the CT online application, you can actually -- I can find some screen shots here. So this is what the online application screen looks like and -- on the department's website. And this entry number here, this entry right here, it's entry number five on the menu, that presents a person who

applies for any kind of license with the radiologic technology. And this is for certified rad techs by endorsement.

So you can actually use this menu item. When you do, it drops you into this screen and shows you essentially the equivalent of all the instruction information that would appear on a paper form. Talks about what you have to have and the rest of it.

So if you have no CT license at all, if you have no license at all, you would come here to apply by endorsement. So this is the pathway that Chantel's members should have been using, would've been using. We haven't gotten detailed information back from Chantel about which particular people. I don't think they gave her enough detailed information to be useful for diagnosis purposes on our end. So we just kind of jumped in and started fiddling around, trying to figure out what we could find.

So the first screen is an instructional screen. If you press next here on the bottom right, it takes you to the following. And it starts to ask you some of the basic initial questions with the way this system is designed. Are you 18? These are things

that are in the statute or the application process. Are you 18? Are you registered -- this is the key one in this case. Are you registered with ARRT or NMTCB? Yes, no. Have you completed a two-year program? And depending upon these answers, you get to various screens.

And the one that's relevant to this, this is a -- I am sorry. This is another -- if you happen to have a -- be a military veteran, there's certain kinds of experience you are exempted from certain requirements, so you would fill out this screen, which is irrelevant to the issue that Chantel's folks were talking about.

Then you come to the basic informational screen which is to fill out, you know, the basic information about yourself. What is your birthday, what is your Social Security number and so forth and so on.

So here's where different things happen and here's where it's not -- it's not really an error. It's the system trying to protect the licensing integrity. If you put in a Social Security number here and you've never been licensed before, it will allow you to proceed and fill out, yes, I have a CT license. If you're currently licensed in another

rad tech area, like if you're a general radiographer or in Chantel's case, if you're a nuclear medicine technologist, when you put your Social Security number in the screen, the system is going to look for existing licenses. And it's going to find them, because you're, you know, a nuclear med tech or you're licensed as such in Florida. And it's going to throw this error up here. It appears from our records you've already got a record -- actually a license in our system; therefore you cannot apply for additional licensure through this mechanism.

At this point what you have to do, if you're the nuclear med tech and you wanted to add the CT, you have to bounce back to the PDF application, which is on the same site and fill that out and submit, not apply through this interactive online system, which allows uploading of documents and so forth and so on.

So in a way, it was designed this way. What's happened, though, is there's no alternative pathway. We had such a pathway when we first put the system up. I don't know if you remember when they put the system up in, gosh, I don't know, 2010 or something like that. There were literally 20, I think, or so, different -- this is option number five. There were

20 or so different options on the front screen. And the system was not designed to be able to, for example, I want to be a GR. Well, you want to be GR by exam or you want to be GR by endorsement? Do you have a veteran with GR by exam or veteran by endorsement? So every single kind of license you could think of, there were about five different individual ways that you could pick from the menu to be licensed by. It was just absolutely overwhelming. So we started combining some things.

So this particular option five here is the option for endorsement pathway for all of the different kinds of licensed technologists except for basics.

In that process, we eliminated the ability to add a license because we were simplifying down. So now we have a ticket open with the IT department to basically add that back to this online system. This will cost a little bit of money. Undetermined. Hopefully doesn't involve any programming by the subcontractor because then it's a lot of money. Something like, I think they bill at like $1400 a hour or $1400 a day per hour or something like that. It needs assistant time. But we haven't gotten the response back from the initial ticket. I think it's

quite likely no additional outside programming would be necessary, in which case it's just the in-house staff and there would be minimal cost to it.

The other issue is getting through all of the issues and problems and requests coming in from all the other professions to the IT department. You know, if you guys have ever gone to your facility and opened a help desk ticket and say, oh, it will happen this afternoon, right? Kevin knows this is only true for us. Kevin's help desk person is like three doors away from him.

So this is something that will be fixed. We'll add this and maybe by the next meeting, we'll have some -- hopefully it will be finished, but at least we'll have some progress to report on this particular issue.

The bottom line is if someone does have an existing license and they want to add something else, you're going to use the online PDF form and e-mail it in to us instead of being able to use this interactive system.

KATHLEEN DROTAR, Ph.D.: That was the question I had because we have students applying for their temp license, and they have a -- they may have a BMO license.

JAMES FUTCH: It prevents them?

KATHLEEN DROTAR, Ph.D.: It prevents them. They have to fill out the form and send it in. But it can be e-mailed?

JAMES FUTCH: Yeah. To the department, yeah.

KATHLEEN DROTAR, Ph.D.: Okay. Thank you.

JAMES FUTCH: We had -- we were going through this diagnosis problems with the head of the IT section. His name is Stephen. And he got to this and he said, well, it's really only a problem if they put in, you know, their actual Social Security number. Of course, if they don't, then we have other problems. If you put in a fake Social Security number, the license is issued in the fake Social Security number and then change it. I'm kidding, of course.

MATTHEW WALSER: James, can you go back a couple screens?

JAMES FUTCH: Sure.

MATTHEW WALSER: There was a question that says are you a --

KATHLEEN DROTAR, Ph.D.: Computer tomography.

MATTHEW WALSER: Yeah, I was like, am I reading that wrong?

JAMES FUTCH: No. She had to pick the license

type she wanted. No, you aren't reading it wrong.

MATTHEW WALSER: Right there. Yeah.

KATHLEEN DROTAR, Ph.D.: Under military.

MATTHEW WALSER: Are you a --

JAMES FUTCH: Look at the previous screen. It's not showing. There's a screen where you have to pick the license type and she picked from the drop down, CT, and it came back with this question.

So when we set the system up originally, all of the professions were listed as the name of the professional. So you were a general radiographer. You were a nuclear medicine technologist. And then years later when we had the authorization to do the specialty technologists, like the computer tomographers, it just grabbed the type of license that we had used in the regulation, which was, are you certified in computer tomography? Do you have a license or do you want a license in computer tomography?

So we need to go through here and use the same thinking from top to bottom. But I've got to tell you, this looks so simple from this end. But you get into this thing --

MATTHEW WALSER: Just put another ticket in.

JAMES FUTCH: Yeah. Two years from now, they

will fix that. I'm sorry, did I say that?

There is a certain amount of unhappiness in not, not in the Bureau of Radiation Control's world, but in the MqA side with the Department of Health with this online system. Unhappiness to the degree that they really don't want to continue with it. I don't know if they have enough money or time or management willpower to go to something else. I'm hoping I'm retired by the time they do.

(Laughter)

NICHOLAS PLAXTON, M.D.: What would be the other option? Like hand forms or something?

MATTHEW WALSER: We used to be hand forms, right? I know in the PA side, it was and it was very, very slow and painful.

JAMES FUTCH: We never lost the ability to use a piece of paper or a PDF. A slightly modified version of a piece of paper.

MATTHEW WALSER: Okay.

JAMES FUTCH: There was a previous online system. I don't remember that much about it.

KATHLEEN DROTAR, Ph.D.: It was even bulkier than this one.

JAMES FUTCH: There were other -- this is all provided by subcontractors. Originally, the

contractor was a Canadian subcontractor back when we first moved into the system in 2005 and we worked for literally a year on this one profession, building all the rules and helping them to understand how it works to get that old system to work. And this current one is another subsequent contractor. I assume -- I think they've actually said this -- I can't remember the names. There are other folks out there who can provide online licensing.

The Department of Business and Professional Regulation, apparently we use -- we used to use the same system. And I'm not sure if this particular piece is what they're using or not. DPR for the veterinarians and real estate agents or whatever else they handle. They seem to like theirs.

KATHLEEN DROTAR, Ph.D.: As the end user, with students, because we use the system about every four months, and it's different every time. We go in which, it's okay, we can deal with that part. But the -- it's not -- it's more user friendly than some of the previous versions, but it's still, with the student that have or graduates at this point that have the temporary license, when they get their ARRT information, they're supposed to send it in. Well,

they can fax it in. But there's -- and I think the letter they get tells them they can upload it, but there is no site or there is no way on -- when you have the temporary license account, to go in and add in documents. At least we couldn't find one. It might go back to this same kind of thing they're trying to fix here.

JAMES FUTCH: Yeah. I will try have an MqA representative here next time because everything you speak is something that we've heard and reported. And we belong to the Bureau of Radiation Control. We work for the Department of Health. MqA is a entirely different section and there are lots of folks. There's lots of professions.

KATHLEEN DROTAR, Ph.D.: There's lots, yes. And the staff is extremely helpful. And Gail has made such a big impact on the efficiency since she's been back.

But, you know, Matthew mentioned having done the paper version. And we used to do the paper version. My -- our students would graduate on Friday and they'd have a temporary license issued to them on Wednesday, the following week. And now we're like a month later and maybe we've got one. So -- and it's, you know, there's no consistency.

So -- and, you know, I know that that's not you.

JAMES FUTCH: Well --

KATHLEEN DROTAR, Ph.D.: It's things that --

JAMES FUTCH: We're all the Department of Health.

KATHLEEN DROTAR, Ph.D.: We're thinking things that could be worked out and we'll be happy to help.

JAMES FUTCH: My brain was educated in physics and I like to see things simple. And usually, the simplest solution is the correct one. I don't really suffer much with all the niceties of the human interactions and the different levels of management, and why can't we have this and why can't we have that. And then you throw lawyers into it -- I apologize to anyone who also has a law degree. But if I could make it so by my human actions, I would do so. But anyway.

So that was one of the issues. And the other one Christen had raised was the business by which the RA has to report their supervisory relationship. Let me close this out and jump to a different section here.

And Matt, actually you were part of this discussion, I appreciate very much. Christen referenced what the PA used to report the

supervisory relationships with their physicians. And essentially asked the question, can we do that? Can we do it that way? They currently send something in on a piece of paper that meets a regulation that says they have to have license number, name of the physician, license number for themselves and their name. Has to be done within 30 days and basically that's, you know, that's it. You have to have that.

And so, we reached out to Stephen again, and he came back with some screen shots of what that physician assistant mechanism for reporting the supervisory relationship in the same online system we were just talking about for the other purposes, what that looks like. And so this is -- and Matt, since you've actually had to do this, feel free to jump in here and tell me if this is wrong or tell me this is right or whatever needs to be said.

But Stephen has identified some areas -- obviously, it's a search screen. You put in where you're looking for the licenses. This is one down here on number two where a license for supervising -- for a person that is a supervising physician is entered already. And you could delete it if that relationship is gone. So this is Dr. --

I don't know if this is a real doctor's name or not. I apologize if it's a real doctor. Stephen usually puts in fake information for this kind of stuff, but we'll pretend it's a real doctor. I'm also kind of afraid to read some of these because when IT people go to make up fake names, you never know quite what kind of sense of humor they have.

So this is where you would enter trying to find somebody new. This is somebody who's already there that you could get rid of. If you did want to go add someone new, this is the interface that you'd use. Add related license they call it. The system is for establishing relationships between licenses. In this case, a supervisory relationship.

You apparently have a drop down here that you can put in the kinds of relationship. He didn't give us, I think, all of what those were. In this case, he just picked supervised by an MD. Your role is the supervised PA. And then you'd put the license number, for example, of your new supervising physician here to go to look them up.

And in this case, they've added a relationship for whatever this license number 123456. I'm pretty sure that one's fake. And so, here's the new person that's been added for this PA as another supervising

physician. This Dr. Smith.

Seems pretty simple.

MATTHEW WALSER: It is. It's a little bit clunky when you first get on there. Like, I have 30 something supervising physicians on my list.

JAMES FUTCH: You have 30 listed on this screen right here?

MATTHEW WALSER: Yeah. And I constantly, as we have people on ortho that come and go, fellows that may work ortho care and I'm under their supervision when I work an after-hours shift, I have to kind of stay on top of who's around and who's not around and our business office does a good emailing every PA, this doctor is leaving on this date and this doctor is coming. Update your license, it's on you. I get on this thing every couple months and make sure the doctors that are on there are actually people that I work with.

JAMES FUTCH: Do you have a certain timeframe that you have to report?

MATTHEW WALSER: Thirty days. So it will not let you add anybody until the day of that you -- like, if they start working on --

JAMES FUTCH: I see. You can't do that ahead of time.

MATTHEW WALSER: October 1st, I can't go in September, even though I know they are already credentialed, they have a license, I can't add them to my list until the day they get there. And then I have 30 days to do that. So -- and then if they leave, I have 30 days to get them off.

JAMES FUTCH: My guess is when the Florida Radiological Society got the radiologist assistant added in Florida back in '08 whenever it was, we must have had the PA relationship in mind because the same 30, 30-day time period we put in the regs. back then.

I do have one question. So when you add the physician, does the physician get any kind of notification?

MATTHEW WALSER: I don't think so.

JAMES FUTCH: That's interesting.

MATTHEW WALSER: So if you go to their license, like if you go to Florida license look up and find them, there are a couple tabs. There's general info. There are --

JAMES FUTCH: Practice location.

MATTHEW WALSER: Subordinate practitioners. I'm a subordinate to the physicians and they make sure they remind me of that.

(Laughter)

MATTHEW WALSER: It's a running joke. But -- and then it will have a list of all of the PAs that work under, you know, under their supervision. And then it has, like, secondary locations, you know, if they work in different offices.

JAMES FUTCH: So the public or whoever can actually go and see it.

MATTHEW WALSER: Absolutely. Absolutely.

JAMES FUTCH: All right.

MARK SEDDON: Do you have any facilities to look at? Do their medical staff offices for privileging have any tie into this at all for you? I guess as a support PA whatever, whatever, whatever classification, category they provide privileges usual, it's under a specific physician. How does that tie to this?

MATTHEW WALSER: I'm not sure I understand your question. Like in terms of facility or --

MARK SEDDON: Yeah, for privileges at a hospital or facility.

MATTHEW WALSER: Yeah. So when we get, like at UF Health, I'm privileged to work at all of the different towers and the off-site locations, if I request that. So we have a office in Leesburg.

Well, I'm never going to go to Leesburg so I don't have privileges to go to Leesburg. But that's really through the hospital. And then as far as the State goes, any place where I'm practicing medicine, I have to let them know that. And so it's on me to let the State know that I'm going to be at the three hospital towers, student health care center, athletics is another one. That's kind of off site for us.

MARK SEDDON: Right.

MATTHEW WALSER: But I don't think -- I mean, like the --

MARK SEDDON: You don't have to let the facility know your supervising -- who your supervising physician is?

MATTHEW WALSER: Yes. They, they have a list.

MARK SEDDON: They have a list.

MATTHEW WALSER: They have a list.

MARK SEDDON: As a licensee, you're responsible, as a PA, you're responsible for notifying the State, updating that and also notifying your facilities?

MATTHEW WALSER: Yeah. I think the department business office does that for us. And most certainly every two years when I go through

re-credentialing, I get a packet and they say, hey, make sure this is correct and sign it and send it back to me.

I've been there 13 years and I pretty much just look over it and sign it and send it back, so -- I don't know where they get that list. I guess they get it from the website. It looks like a print out from the website.

JAMES FUTCH: The online license look up?

MATTHEW WALSER: Mm-hmm.

JAMES FUTCH: They're adding new stuff to that all the time. It's always kind of surprising to go see what's there.

What do you see, other than this entry when you go to click this drop down?

MATTHEW WALSER: DO or MD, or DO.

JAMES FUTCH: That's the only two? The feedback from this, this is very minimal cost. We essentially use -- if we change nothing, except for, you know, of course, would be there an entry here that says supervised by, I'm assuming MD or DO. Your role would be supervised RA.

MATTHEW WALSER: RA.

JAMES FUTCH: Or RRA, whatever language we're putting in there. And that would be -- there's a

little cost. But it's like a maintenance fee that's very minimal per year to the subcontractor, not like a programming fee, which we could absorb that. That would be really --

MATTHEW WALSER: I will tell you as an end user, for me to go and swap out people, it is so much better than the way it used to be. Before, I had to have a typed form. I couldn't write it out. It was typed. Had to be typed. So you have to go find a typewriter. And then I had to figure out how to use that thing.

(Laughter).

MATTHEW WALSER: Make sure it was actually, I think it's on the right line. It was a disaster. Every time a doctor would come or go, I would have to start all over. And then I'd have to mail it to Tallahassee and I just hope it got to the right place. Not really knowing. Because it's my license. And if somebody ever came for an audit, and that last copy didn't get there, then it's some ridiculous fine. I know people have been fined for not taking people off their list. And it was hundreds and hundreds of dollars.

JAMES FUTCH: Okay.

MATTHEW WALSER: Some doctor moves to Atlanta,

Georgia and he just happens to still be on your list, and you're not working under him or being supervised by him, but he's still on the list, it's still hundreds -- it's like 300 and some dollars or more per person.

REBECCA McFADDEN: Wow.

MATTHEW WALSER: It's serious. I don't want to get caught like that.

JAMES FUTCH: So if it's -- the sense of the council, we'll proceed along with this path and see if we can get this added for the 34 -- 32 licensed professionals. I'm sure the number will change when the reimbursement changes at the federal level.

I, unfortunately, can't tell Christen. She's -- I don't know if you want to mention this now or you want to save it for the member sections. But Christen is home with her new baby and has expressed an interest -- her term is up, along with some of the other folks, in about two weeks or so and she's not going to -- doesn't want to serve again at this point. So we'll have a new RA next time if we can get the paperwork through.

REBECCA McFADDEN: Do you have someone in mind?

JAMES FUTCH: We always go back to the society.

REBECCA McFADDEN: Right. There's a society

that does that.

JAMES FUTCH: In this case, it's FRS. It's the Florida Radiologic Society. The radiologists. And they've -- I think they've sent someone, very preliminary. But I think it might actually be someone from University of Florida.

REBECCA McFADDEN: He's over here cracking a joke. This guy over here in Gainesville. That's how they do it up there. He's over there -- there's only 31 operations because there's only one out. So I think I'd share that tidbit with you guys.

MATTHEW WALSER: I was trying not to get that on the Record.

REBECCA McFADDEN: That's okay. You have now been put on record.

JAMES FUTCH: So that's it for action items related to MqA and MqA updates. Any questions? Bring an MqA person next time?

(Laughter)

RANDY SCHENKMAN, CHAIRPERSON: I think being that, you know, you feel this is so much easier, it makes a lot of sense to simplify the whole process instead of keeping it so complicated.

MATTHEW WALSER: I think somebody asked the question does the physician know -- do they ever get

an alert that I've put them on my supervisory list? I don't know the answer to that but I, I think that would -- I mean, if I were a physician, I would want to know that because I could go in there and type anybody's name in there and have them be a supervising physician for me. And that, liability wise -- I mean, for the people I actually work under, it's no big deal for them. They know me. But I could put six doctors from the private group across town on my list and they would have no idea. Or a PA that has worked for us, and maybe she only worked for us or he worked for us, I'm thinking of somebody specifically, for six months and they weren't very good and we had to give them an opportunity to get better somewhere else, and if they don't take the physician off their list, that's a liability for them, too. And I just don't know if they get that alert. I don't think they do.

MARK SEDDON: That's what I was thinking that for hospital privileging, that might tie into that. I think that is more formal with you, in regards to when they have folks working underneath another physician at a hospital. So it's usually the removing privileges is pretty quick at a hospital setting.

MATTHEW WALSER: Getting them is not quick.

MARK SEDDON: No, it's not quick. Removing is pretty quick. That's why I was thinking about notification if someone does lose their authorization.

MATTHEW WALSER: Yeah. I think that would be interesting because when I do, when I make a change, within seconds, I get an e-mail that says I have changed something.

MARK SEDDON: Right.

MATTHEW WALSER: Or something has changed on my license. It's an automated response. So maybe the physicians get an e-mail and they, you know, they also get 700 other e-mails in a day and it just gets lost.

JAMES FUTCH: Matt, do you have perhaps any of your supervising physicians you might be able to make that inquiry and let us know?

MATTHEW WALSER: Maybe I could drop somebody off and then add somebody and see what happens.

JAMES FUTCH: And I will say this: Whatever happens with the PAs, they're not going to change it for the RAs. We'll be using this exactly in the same, you know, way, words, backgrounds, IT coding and all the rest of it. Because they're not going

to recreate this particular wheel for a profession of 32 people.

MATTHEW WALSER: I think ultimately, it works pretty good. It's way better than paper.

JAMES FUTCH: That's all for that option.

RANDY SCHENKMAN, CHAIRPERSON: Okay. So now we have Clark.

CLARK ELDREDGE: All right. Well, as Cindy mentioned, we currently have no vacancies in the program, which is a good thing. I believe at this time last year, during renewals, we were down two regulatory specialists while we had a hurricane to deal with and that kind of put a big crimp in the processing of the renewals.

Currently, we have, you know, over 1900 -- 19,300 facilities registered and over 58,300 machines. For MqSA facilities, that makes up 576, up from the 564 last year. There were contract for last year in the licensees.

Chiropractic facilities about 1500; dental about 8,000.

All of the medical which, you know, diagnostic imaging centers, hospitals, doctors, mobile, osteopathic, about 5,000.

Educational, industrial total about 1200

facilities.

Registrations dealing with therapy, about 500, but that includes both the primary accelerator and the associated imaging with the accelerators. And, of course, the specific x-ray therapy systems.

Podiatry, about 640. Veterinary is about 2,000.

So as of last Friday, we actually processed about 2600 of the renewals. And so that's pretty good for the first two weeks.

We worked on a training for, statewide training for the MqSA inspectors September 10th and 11th at the Orlando lab, so we brought them in. We had FDA staff show up. They had just finished auditing a number of our inspectors prior to that and so they actually used the results of that audit to help guide their training to kind of reinforce their -- help pick up weaknesses, anything they identified.

Overall, the comments, we've yet to receive a formal response from FDA after their audits, but overall, the comments, or the things -- the evaluation of the inspectors was positive.

Mr. Seddon, with his wonderful folks, helped us out. If you wouldn't mind telling them what you did for the MqSA training for us.

MARK SEDDON: Yes. So one of the requested training topics was to focus on the physics report and Q and A with physicists for the inspectors as far as what they should be looking when they're doing an inspection or evaluation of a site for mammography.

So I provided a team of five of us physicists, diagnostic physicists to do some training. We went over some of the key issues they should be looking for when they're reviewing a physics report from the different vendors and what they should be expecting in a physics report as far as what is a good physics report.

They actually spent about a hour and a half with Q and A for what type of questions they had technically for the different type of equipment that's out there. Obviously, with the technology change with the 3D, contrast enhanced, all the newer technology, mammography, it's changed a lot back from the days of screen and film.

So we spent about two-and-a-half hours total of training with all the mammography inspectors and I think overall, it was well received. And good for them to have that opportunity to ask questions when they don't really have a chance to.

CLARK ELDREDGE: It was great. We actually had staff, when you get your staff writing e-mails about how wonderful the training was, it means -- made a big impression on them, and they really appreciated it. So we did get some good feedback on all that.

Okay. So we actually have a legislative proposal that's made it to downtown at this point. Page --

JAMES FUTCH: Third page after the agenda. Looks like this (indicating).

CLARK ELDREDGE: So the purpose of this, the main goal of this, of course, is to try to kind of bring right -- refocus how registration is currently done. The focus in registration right now is who's operating the machine, not the particular risk or hazards. Because let's go back to, you know, 1980, and who was operating the machine may very well have represented the risk and hazards. But the way the registration is written, it hasn't really allowed the fact that dentists are adopting CT machines and psychiatrists are adopting CTs and there are more dental machines in hospitals and things these days which are whole different, you know. So there's a -- the approach is changing. So we're trying to, in the language, focus on the machine and its use as

opposed to who's operating the machine.

JAMES FUTCH: Or the kind of facility.

CLARK ELDREDGE: Or the kind of facility, right.

The other part of this is, of course, the fees were -- we removed the hard fees in the statute and just referencing the whole thing that the fees need to be adjusted for how much it costs to do the work, which it says in the statute but then they didn't, again, put the limits on it. We've been at statutory limits for quite some time now.

And then a third part of this was language that actually adopts personal health and safety benefits of direct radiation exposure into the statute. And to clarify that, that's sort of an operational way we've been using radiation, directly exposing individual radiation for decades, was the fact that, you know, there should be some health benefit to the exposure. You just don't put somebody in the beam for whatever.

So the categories, let's see here. Or the way the categories -- if we -- page three is -- yeah. So let me make sure I've got this right starting point. Okay.

Actually, the second page of this. Radiation

machines that are -- have a peak voltage greater than 80 kV, are used to intentionally expose natural persons to the useful beam and used in but not limited to, and then the parts that were in there before. So basically, this describes what was the machine. You know, diagnostic machines, et cetera, at the time. And really, that's what they were going for was what was the machines used by doctors and whatnot. But of course, as I say, those machines have been moved for other uses.

The next section, radiation machines that have a peak voltage equal less than the 80 kV and used to intentionally expose natural persons to the useful beam, and used in but not limited to, and again, the practice is dentistry and podiatry you put there. Basically saying that these machines should be inspected at the same frequency they were before.

Radiation machines which are used for therapeutic purposes and the healing arts. Now, we do have a whole, you know, veterinarians have started taking good old human therapeutic machines and putting in animals. Now, they are operating the machines the same way. They basically have the same risks to the personnel, you know, whatever. So I don't see at this point, why they should have been

treated -- currently, they've all agreed to be registered and treated the same way. The veterinarians have agreed to be registered and treated the same way as therapeutic machines for human exposure. So accelerating from that point, so we're putting those together and having the same annual inspection.

Then we've got accelerators, do not expose natural persons to the useful beam. Good old industrial. Radiation machines that are not intended to expose natural persons. In general, but they're not covered anywhere else, so that will cover all veterinary, diagnostic, all the general industrial stuff as it is now. And so the difference throughout here, the theme is whether or not you're putting somebody in the useful beam or not.

Because we really don't -- honestly, we don't care how the machine is operating if you're not putting a person in front of it. That's a problem for the person using it to make sure it's getting the result that they want. While when you actually put a human in the beam, then we do worry about that you're doing the least exposure to get the most information.

And I've got their machines that meet more than one of the criteria listed shall be inspected the most frequent schedule applicable.

So now, we've added a maintenance thing. This is in line with the significant advent of the internet and purchasing parts and pieces online. This is really geared towards the folks who are doctors and small diagnostic facilities that really aren't maintaining their equipment to any particular standard. And reports we receive from concerned employees and things at these facilities about the source of the materials and the fact that if they're not purchasing equipment that actually is, you know, you can get stuff from China and everywhere they will say be equivalent, but is it really equivalent equipment. And putting the onus on the operator to make sure they're taking due diligence in purchasing a machine or this equipment for -- again, this is only direct exposure of people supposed to be in the beam. Make sure it's going to not validate -- invalidate their FDA approvals and things like that for the machines.

And then the next page is talking about the -- adopting the standard for there needs to be health. Now because since this whole statute was written, we

now have security exposures of persons. We then want to insure that the individuals being exposed for security purposes are actually also, it's a health benefit for them. I mean, a life safety benefit. That they're not just being exposed to a radiation dose when it's not a direct life safety event to the individual exposed. And, you know, and that would allow for security, transmission x-ray security inspections of humans -- of persons when there's a reason for their own benefit for that investigation. That inspection.

JAMES FUTCH: But not shoe fitting fluoroscopes.

CLARK ELDREDGE: Excuse me?

JAMES FUTCH: But not shoe fitting fluoroscopes.

CLARK ELDREDGE: Not shoe fitting fluoroscopes, right. Not shoe fitting fluoroscopes, yes.

So that's what we've got. It's actually downtown. It's supposedly been -- we have not actually seen a bill that's been attached to, but it's supposedly put in, it's in bill form somewhere. We haven't just seen it. We haven't seen it actually show up on the legislatures -- legislative system yet.

RANDY SCHENKMAN, CHAIRPERSON: Do the machines in the airports get checked regularly?

CLARK ELDREDGE: Which machines in the airports?

RANDY SCHENKMAN, CHAIRPERSON: The ones --

MARK SEDDON: Security.

RANDY SCHENKMAN, CHAIRPERSON: -- that you have to stand and do this.

CLARK ELDREDGE: Those are millimeter waves and are outside our jurisdictions. They're not ionized.

ADAM WEAVER: They are not ionized.

CLARK ELDREDGE: When they first came out with those, they were actually -- they were the backscatter x-ray machines. There was enough public human cry that the federal government backtracked and had all those pulled out and put in the millimeter waves instead.

NICHOLAS PLAXTON, M.D.: What is that technology? Is it millimeter wave?

CLARK ELDREDGE: It's microwave.

NICHOLAS PLAXTON, M.D.: Oh, microwave.

ADAM WEAVER: You have to get -- do you have a proposed list of the standards that you're -- the national or consensus standards that you're looking at?

CLARK ELDREDGE: Basically, everything the medical community thinks is a good idea.

ADAM WEAVER: So you're talking ANSI, AAPM, whatever.

CLARK ELDREDGE: Whatever. AAPM has a bunch of good stuff. That's, you know, there's actually even stuff from Joint Commission and stuff about how to maintain your machine. So we're quite acceptable and open to what is considered. As I say, as long as it's what the manufacturer says this thing needs to be calibrated whatever, you know. That's going to be --

ADAM WEAVER: I guess my concern is more of the industrial side.

CLARK ELDREDGE: It doesn't apply to industrial. It won't apply to industrial. It's only --

ADAM WEAVER: You said there is a --

CLARK ELDREDGE: The machines where humans are put in the beam intentionally.

MARK SEDDON: Number six.

ADAM WEAVER: There is one for not intended to expose.

CLARK ELDREDGE: It's not intended to expose natural persons.

ADAM WEAVER: You're just saying it's going to be inspected.

CLARK ELDREDGE: Oh, no. This is -- the standards are for the maintenance of the machines that are intended to be exposed to natural persons. That's where that was --

MARK SEDDON: I think Adam's question is for number six, basically, it seems to imply any machine not intended for use on people is to be inspected at least once every three years.

CLARK ELDREDGE: Years, which is what it is right now.

ADAM WEAVER: What standard? Are you going to change the standards? Are you going to -- we're using the FDA now. The 10, 21 CFR 1040. Are we changing the exposure limits to something newer? I'm just worrying because there's some older equipment, especially in a university, like maybe some industrial machines.

CLARK ELDREDGE: There should be no effect. Any of this should not affect any of that. Because the inspection -- the inspection standards are -- we're trying to maintain the inspection standards the same for all the current equipment. Other than, again, devices that meet these -- we might have some

hospital machines that only need inspected every four years, et cetera. Some dental that may have to move up to every two. But other than that, all the industrial machines that people aren't in the beam, nothing should be affected. And then we have the maintenance schedule type stuff, maintaining the equipment. That is only for machines that people are put in the -- that humans are stuck in the beam. And if you're not putting people in a beam, then the industrial research --

ADAM WEAVER: Okay. I mean, like for instance, a veterinarian -- not a -- you have a C Arm. That's designed for humans, but it's not used on humans.

CLARK ELDREDGE: Right. If you're using it as industrial, it's not affected.

ADAM WEAVER: Okay. I'm just wondering, everybody always wonders how do we inspect that machine? Are we going to treat it like it's a human one and lower the dose rates and those kinds of things?

CLARK ELDREDGE: No.

MARK SEDDON: I guess that's a good question. So the C Arm, which is, so the vendor would provide, like it's a medical, because it's an FDA device.

CLARK ELDREDGE: Once you stop using it on

humans, from regulatory, it's industrial. We don't care how you use it. But then we're always worried about operator protection.

MARK SEDDON: Right.

ADAM WEAVER: Right.

CLARK ELDREDGE: But not the --

MARK SEDDON: Not the outputs.

CLARK ELDREDGE: At that point, it's whatever makes the best quality for your own purposes and that's outside our concern. When you're --

ADAM WEAVER: I wanted to --

MARK SEDDON: How you register it would determine.

CLARK ELDREDGE: Yeah. How you initially registered it.

ADAM WEAVER: Okay. I'm sure we're not the only place that has --

CLARK ELDREDGE: Yeah, yeah. That's somebody if you wanted to do artwork, could get any diagnostic machine, to put their, you know, scatter their materials to say x-ray, and make x-ray art type thing and that would be --

ADAM WEAVER: And I guess, in regard to, you know, we've getting more and more cabinets. I mean, these new x-ray machines are getting so small.

MARK SEDDON: That's the question just with the cabinets, the specimen imaging systems that are --

ADAM WEAVER: Yeah.

MARK SEDDON: -- all those have to be registered as, I think that's a question people always have. I don't think we get an answer sometimes. Is that industrial or is it medical since you're using it on patient tissue but not technically on patients.

ADAM WEAVER: Right. If they x-ray tissue taken out of a person.

CLARK ELDREDGE: Yeah, at this point, if it's not a living, complete human --

MARK SEDDON: It's industrial.

CLARK ELDREDGE: It's industrial.

MARK SEDDON: Okay.

ADAM WEAVER: So it goes to how you register it. Okay. All right. I mean, I don't know. You may have -- like hospitals a lot of times just add it.

MARK SEDDON: Everything to the one hospital registration.

CLARK ELDREDGE: Yeah.

ADAM WEAVER: For pathology.

CLARK ELDREDGE: For convenience, you could

have multiple registrations, but it's for the convenience of the hospital and it may be actually a lot more cost effective for them to do that, than having us only come in once every couple years to interfere with their operations rather than having somebody come in every other odd year to look at their other industrial machines.

ADAM WEAVER: I guess the only other question I have is what is the fee schedule going to look like? Now it's pretty well spelled out. Have you guys worked on the fee schedule?

CLARK ELDREDGE: We don't anticipate touching the fee schedule any time soon just because there's no cost justification to the agency at this point. In fact, that's in our bill analysis because, you know, if technology changes somehow that would impact us, if we have to buy some more equipment or something, something that impacts the cost of the agency, that's the only time we look at the fee schedule.

ADAM WEAVER: Right.

CLARK ELDREDGE: And the fact that while we actually should, you know, if we wanted to be truly technically correct or whatever on this, we would actually look to try to adjust to make sure that all

the machines that meet this were actually properly registered at their fees.

The cost to the -- the cost, you know, looking at the total numbers involved, the total number of CTs and dental, the total number of medical, whatever. In the hospitals, both the dental and the cabinet biopsy machines, things like that, I don't -- the numbers involved really don't look like any of the cost shifting would really justify the effort and whatnot. That the efficiencies gained from it wouldn't -- would benefit -- would be greater than the cost actually implement the changes to the folks overall.

You know, the fact that you would actually have to worry about setting up your own internal tracking within your own facilities and that overhead costs to implement those as well as, we just don't see, at this point, that it would make a, you know, net benefit to society to adjust for those differences. But if things change radically, it would.

ADAM WEAVER: Yeah, you justify it.

CLARK ELDREDGE: Yeah, justify it. At this point, there's no financial justification for it.

ADAM WEAVER: Because I just -- so there's going to be a separate or there is currently a

separate fee schedule somewhere else in the --

CLARK ELDREDGE: We -- yeah. We would -- no. The schedule, we just take our current schedule and make sure -- it's in the rule and we wouldn't change it.

ADAM WEAVER: It's in the rule now. You just, you just removed it by the type of machine.

CLARK ELDREDGE: -- machine. Yeah, we just, we would keep it the same.

ADAM WEAVER: You do mention --

CLARK ELDREDGE: Again, we'd adjust language in the rule to reflect this, but we wouldn't -- we'd still look at the, all the categories pretty much stayed the same until there was some significant enough change, but at this point we're hamstrung if there was a change and we actually are seeing progressive shifting in changes of uses of machines between categories and --

ADAM WEAVER: Yeah.

CLARK ELDREDGE: -- and the current way it's written, it just doesn't allow for technological change and shift.

MARK SEDDON: Since all of this is dependent upon how somebody registers the machine, what type of inspection enforcement or however you do it, to

confirm that people are actually registering things properly? Because it seems like that is really now, a lot of the responsibilities is going back on the registration, properly registering the proper categories.

Do you guys have -- I don't know. Is there anything on the inspection side, your side that you have some way to capture when machines aren't registered?

CLARK ELDREDGE: When machines aren't registered, period? Of course, that's the 2509, 1114 requirements from vendors who sell the machines.

MARK SEDDON: Right. That is still --

CLARK ELDREDGE: Install machines.

MARK SEDDON: Install machines.

CLARK ELDREDGE: That's still there.

MARK SEDDON: Assuming that somebody submits the 2509, I assume the process goes back to down to you guys. Then if somebody registers that machine under the proper category or there's a secondary seller who sells it or doesn't -- specialized cabinetry, C Arm, you probably have -- the variance used to be in the hospital and transferred over, I would assume.

ADAM WEAVER: Yeah. It actually depends on where they get the money. Sometimes it's a refurbished machine, but sometimes it's a new one. A lot of times we just get them based on whoever has got the money and then a lot of times, the machine goes away when the money dries up. Research.

CLARK ELDREDGE: There are issues currently right now with industrial users that we probably have some lack of registration or lack of compliance that we've been looking to figuring out how best to address. Any industrial users, gold industry, precious metal folks. We did have the case a couple years ago where a dealer down in south Florida had been holding his jewelry for three years and claiming to do several hundred or more shots a year into his hand and after three years, he started having neurological problems in his hand. And he had bought it from a guy down the street. His XRF.

ADAM WEAVER: Just a handheld?

CLARK ELDREDGE: Little handheld.

ADAM WEAVER: Because those are being made in foreign countries that are not -- they're easy to buy off of EBay or equivalent systems.

CLARK ELDREDGE: Yeah. And so, yes. That's a whole, a whole area we're trying to figure out how

best to --

ADAM WEAVER: The registration --

CLARK ELDREDGE: -- to get that under control. And but with the internet, that's another part of the technology thing that's outstripping or --

ADAM WEAVER: Yes. You've had a few of those people trying to come in and use, especially, well, we're not going to talk lasers now.

JAMES FUTCH: You're holding --

ADAM WEAVER: You're holding a laser.

JAMES FUTCH: You made me.

CLARK ELDREDGE: I wonder if mine --

ADAM WEAVER: Where did you buy that from?

JAMES FUTCH: Are they as cheap as these? Because when they get as cheap as these, you've really got a problem. I'm sorry, laser pointer. So it says it's FDA compliant with 21 CFR 1440. It says it's a Class 3A laser system with less than 5 mW output. My green laser, Clark has got one that says the same thing. We noticed one day that seemed awfully bright. And we measured it and it was 45 mW, which is Class 3B.

ADAM WEAVER: A lot of times they don't filter out the blue. It's very powerful.

CLARK ELDREDGE: Yeah.

JAMES FUTCH: This is green. Are the x-ray, the small x-ray systems --

ADAM WEAVER: You don't see very much of it, but we do have, like we have a guy in anthropology who just bought a dental x-ray machine. And we don't have any idea where he got it from. It's a Diox, D-I-O-X. And he thought he could, you know, hold it by hand and x-ray skulls. Not living people. But he also didn't want to bring it overseas, which is another issue for us in regard to export control and those kinds of things.

CLARK ELDREDGE: We've had a dentist who surrendered his handheld x-ray machine to us because he purchased it off EBay. There was no serial number on it. No way to provide proof that it was either American, you know, built for the U.S. market or not; and so therefore, he surrendered it since he couldn't use it.

ADAM WEAVER: Which is a challenge on both ends. The user and the --

JAMES FUTCH: Have we seen, like, deliberate fake labeling to pretend that it met U.S. requirements yet?

CLARK ELDREDGE: No. Well, not anybody's recognized.

JAMES FUTCH: I've seen that with lasers.

ADAM WEAVER: You see it a lot with lasers. I don't think I've seen it -- we have an x-ray machine from Russia we won't let them use. It's registered, but it doesn't have all the interlocks that we would like. We've run out of money, so we still have the machine in storage.

MARK SEDDON: Will electronic bracket still have a separate section?

CLARK ELDREDGE: It's still EB. I forgot to list how many EBs there. It's like eight. There are not that many. I had them in the wrong category. There are eight. Eight registrations and eight machines.

ADAM WEAVER: Good luck getting the bill through. Cindy could get it.

CYNTHIA BECKER: I'm sure.

JAMES FUTCH: The other thing is even if the law passes, when it comes time to implement or change anything in the regulations, Chapter 120 is still going to apply.

CLARK ELDREDGE: Right.

JAMES FUTCH: We still have, unless it's been repealed, the monetary limits of what is it? 250,000 in any one year, a million over four.

CLARK ELDREDGE: Right.

JAMES FUTCH: And you've got multipliers that's going to --

CLARK ELDREDGE: Would kick out anything that was --

JAMES FUTCH: -- put you into that category for sure. So you're going to have to go back to the -- in the rule adoption process. That's going to have to go back through the Legislature.

CLARK ELDREDGE: And that's certainly part of the whole thing is that reason -- and part of that whole thing about, it would have to be enough of a economic benefit for all parties to implement any changes to the fees or shifting around.

ADAM WEAVER: Right.

CLARK ELDREDGE: Again, if we did initial thing, assuming, again, assuming we still had enough to operate on it, would strictly be revenue neutral as a whole would be the goal. Not to, as I say, just to appropriately charge people as necessary.

ADAM WEAVER: They don't want you to make money.

CLARK ELDREDGE: No. And we're not here to make money.

ADAM WEAVER: Right.

CLARK ELDREDGE: You know. That's -- we're here to provide the service that was negotiated between those who are being regulated and --

ADAM WEAVER: The counties that were doing it on their own, set their own schedules. Own fee schedules a long time ago.

CLARK ELDREDGE: I believe last time I mentioned the medical events that occurred right before the meeting. So we've got more information on those.

Moving on to medical events.

So we had three medical events involving breasts that all happened in April. So in one of them, the physician ordered a simulation for the wrong breast. And it went through until 19th, 20th fraction before it was discovered that it was the wrong side of the body.

In the interim, there were two sets of review forms for -- having a different doctor and a different therapist who signed off, saying they looked at the pathology reports and the treatment plan. Which if they actually looked at the pathology reports and looked at the treatment plan and compared, they would have seen the pathology all said --

JAMES FUTCH: The other side.

CLARK ELDREDGE: -- the other side. Of course, then there -- the first was in the simulation order. And the rest, the other time was three days after treatment began, they were looking at the first day's treatment and verifying things for the first day's treatment.

There was also a physician who took over care and began -- this is the physician who discovered it, day 19 of 20, and suspended treatment. Actually started signing all the forms -- order forms for the stuff five days before treatment started. So there's some question there of, if the physician was signing everything five days before treatment started, that how carefully they looked at it. So there are five individuals, including the original physician, who had an opportunity to, at times, compare the pathology reports to the treatment planning.

The facility, in their corrective actions, proposed to add another layer of check of the pathology versus the treatment planning. We are currently reviewing that and are -- do not think that actually addresses the solution and are planning that they request to reevaluate that. The

way we're requesting that is the legal group to address that.

MARK SEDDON: Question. Was the treatment plan to the wrong breast or was it the simulation and treatment delivery to the wrong breast?

CLARK ELDREDGE: Well, it started with the simulation and just carried on through, so everything was the wrong plan, the wrong breast. It started with the physician, well, right breast and all of a sudden, wrote everything left and everything got carried on through.

RANDY SCHENKMAN, CHAIRPERSON: You think the patient would say something.

CLARK ELDREDGE: Well --

MARK SEDDON: A lot of times patients will catch that.

CLARK ELDREDGE: Yeah. That's what happened the next two. The patient caught it. In this case, it was, yeah, that just got carried through. But of course, the person had cancer on both sides. Had had mastectomies on both sides and things like that, so there was a mystery of involvement.

Then we had two cases where an electron boost treatment was done to the incorrect scars. In one case -- well, in both cases, of course, there are

multiple biopsy and lumpectomy scars in the general target areas.

In the first case, the target scar was actually faint and hard to distinguish. The physician did not provide sufficient descriptive guidance to the therapist where it was to be placed. Where the target scar was. In fact, they noted in their comments in the investigation that, yeah, I should have -- it was hard to see and hard to find. The new scar was actually the faintest. All right?

The patient -- and so the, the therapist put the wire on the wrong scar. The doctor then did all the treatment planning around the wire as the target, et cetera, for the boost treatment and whatnot. And patient notified the therapist, prior to the second boost treatment, saying, um, I think that's the wrong spot. And so, there was 200 centigrade electron boost treatment to the wrong location in that case.

Similar thing but slightly different. Electron boost treatment. Again, wrong scar. Again, multiple scars in the general treatment area. However, the target scar was in the supraclavicular region. The CT tech placed the wire on top of a scar on top of the breast. So -- and then again,

this was sent to the doctor for treatment -- for doing the volume treatment plan, et cetera. Looking at that and of course, you can look at an x-ray and you can see that's a significant difference in distance. And so, there were some places here where it could've been caught rather early on. While in the first, the first one they were very close together.

And so, the guidance provided, there was one statement, one line about there was something on the CT scanning and their superclavicle is on there, but it was still kind of weak on the communication with the tech. But it could've been caught by the tech as well.

And again, the patient said, I think that was the wrong spot. And so, after the first treatment, the second day comes in and, are you sure that was the right place? And that was stopped there. So those were those two cases.

Any questions or -- okay.

MARK SEDDON: I should -- so when they did the patient set up, there was a physician actually present?

CLARK ELDREDGE: That's actually what their current -- thank you. The recommendations there is

actually on this case, they're going to actually get -- this facility had -- they neither, neither cases was there any boost treatment SOP. There was nothing about -- now they're actually going to make sure that either in the modeling, in the CT sim, the physicians are actually involved where the wire's placed and verifies the patient -- verifies wire placement before, before the modeling.

MARK SEDDON: Yeah. That's a smart thing to do.

CLARK ELDREDGE: Yeah. So that actually looks like it would directly address.

MARK SEDDON: Not that physicians are infallible, as you say. If it's close to each other and there's multiple scars, they have trouble as well. But at least you have another set of eyes looking.

CLARK ELDREDGE: Yeah. We have -- okay. So we've got some updates to information notices. The one here is actually talking about allowed exposure of humans to useful beam of radiation machine. Again, following along with the idea of medical benefit. And this is -- should be two pages after where you were before.

So in the broader topic of this whole guidance,

this part goes back to, you know, the DEXA folks. DEXAFit and their use of a physician in Michigan who's writing orders for people who come in to a non-medical facility to pay for a body mass index measurement using a DEXA machine. And within that, another case is we actually have currently registered, registered three of these facilities. One of which it is the actual office of a licensed practitioner. And so the licensed practitioner is on site working with the people. So that's fine.

The other one, there is a licensed practitioner who actually has set up a protocol within his facility with PAs and whatnot that actually will, they will actually make appropriate medical determination prior to issuing it and they are actually responsible for looking at the results. Even though he's remote to the facility, they actually will be forwarded to them and have his folks and staff, you know, as appropriately under the practice standards, evaluate and provide the results back to the individual being screened. Appropriate medical guidance.

The third facility actually is under review because while the physician involved in that facility had signed a -- can't say the word right

now. I hate this -- a settlement agreement with the State, saying that they would implement those types of models where the individual coming into the facility, you know, information would be provided to the physician to make sure that it's a medical determination and then the result would be sent to the physician for him to review, provide the guidance, and sent back.

It turned out that the -- upon inspection, that the radiologic technologist was actually operating the machine without knowing that there was any order available. And when the results were provided and they were then turning around and going over the results with the individual receiving the x-ray, in violation of the agreement. And so that's with our legal staff on the appropriate response. And we hopefully will be meeting with them next week to follow through on that violation of the settlement agreement.

We also have another facility currently offering free heart CTs.

ADAM WEAVER: Free heart CTs?

CLARK ELDREDGE: Free heart CTs. And as a prelude to having you sign a five-year contract for full body CTs.

MATTHEW WALSER: Huh?

KATHLEEN DROTAR, Ph.D.: What?

CLARK ELDREDGE: When the facility first came to our radar -- this company came to our radar, they were actually contracting with diagnostic centers to apply the CTs. They then applied for registration of their own to operate their own CT, at which point we asked them for clarification and they've since declined. They've since pulled their registration or their thing for their own facility saying it was uneconomically feasible at this point. After showing them the requirements and how, you know, there has to be the continual loop of a doctor who is providing the intent -- looking at he was a patient, determining his medical need for some concern that the physician had, then the x-ray being performed, and then using that in your care. But they're still performing it with the -- through the secondary contracted facilities. And so we're still -- we're currently reviewing how to approach those since they've chosen not to do it on their own after I guess looking at the rules.

So a part of this is -- the language here is after having the more recent CT one, I'm not sure that this is -- I'm trying to figure out if we need

to reevaluate this draft version we have here. Although it was approved as a draft, it was then pulled back for publishing for that.

So currently, a licensed practitioner operating within their practice standards determines the medical need for the exposure and orders -- this is the lower set of bullets on the front page.

That medical need includes an evaluation of the health risk from the exposure versus the medical benefits, the information gained from the exposure, the licensed practitioner, licensed radiologic technologist exposes the patient. The licensed practitioner operating within the corrective standards, reviews and interprets the results of exposure, provides the medical information to the patient, uses the medical care of the patient.

I guess that final sentence still captures that enough. Uses the medical care of the patient because, of course, in this case, the persons offering this contract for the five years of full body CTs, there's a doctor in the area who is signing these without ever meeting with the patients or the individuals receiving the CTs. And then the CT is sent to a contract group out of state who then reviews the CTs. Does it -- and then they basically

blind send the results to the primary care physician of the individual receiving the CT.

In looking at the Yelp reviews, et cetera, for this facility, there are a lot of comments like my doctor wouldn't let me get one. I finally found somebody who would give me one.

Again, we're not trying to say they shouldn't be done. You know, currently, there is the proposed guidance. I don't know if it's been actually, ALA, I'm not sure anybody else has moved on it, where the -- where screening CTs for lung cancer for 30 day -- 30 year pack-a-day smokers. So there's been evaluation that's -- this is a proposal, I don't know how far it's gone through any of the medical groups. Where they actually are saying that if you've been smoking a pack a day for 30 years, your risk of lung cancer is such that you should consider screening for lung cancer using a CT. Now, of course, they specify low-dose CTs in this case because of the improvement in CT technology that's lowering the exposures involved in the CTs. It's also part of that --

MARK SEDDON: -- has a lung screening program through the HCR, that's a low-dose screening program that requires you to have less than 3 -- I don't

know what the does limit is -- actually less than 3 Gy.

There's a category that you have to meet to be part of the program. So that seems more medical focused than this may be.

CLARK ELDREDGE: Right, yeah.

MARK SEDDON: You're talking more like folks who want to have, like, calcium screening and lung screening. Screening type exams, correct?

CLARK ELDREDGE: Screening, yeah. And so that's, and so actually that was part of it, whether or not in our own rules, I guess this is where looking at, whether or not we need -- looking at language to beef up in our rules and actually mention, you know -- currently our rules say -- I guess I need to switch over my -- where is it? Okay.

James, do you want to pass the -- no, actually we can look at it on this page. Sorry. The page after 640-5.101 has a healing arts definition, which means the professions concerned with the diagnosis and treatment of human and animal maladies, including the practice of medicine, dentistry, veterinary medicine, osteopathy, chiropractic and naturopathy. Say that too many times.

Then 5.501, healing arts self-referrals means testing human beings using x-ray machines for the detection, evaluation of health conditions when such tests are not specifically ordered by a licensed practitioner of the healing arts legally authorized to prescribe x-rays for purposes of diagnose and treatment, diagnose and medical treatment.

And then under 502, administrative controls, individuals shall not be exposed to the useful beam except for healing arts purposes unless such exposure has been authorized by a licensed practitioner of the healing arts.

And it specifically prohibits the following: Exposure of an individual for training purposes; healing arts self-referral except for mammography, which is (a)11. Advertisement of free exams unless the advertisement states a determination will be needed to be made prior to the x-ray examination.

So that's actually something else we're working on with these individuals offering free heart CTs is to get them to actually say that explicitly.

And then so, putting in, finding some appropriate language for saying appropriate usage of the term screening and whatnot, to try to clarify the blind screening, if we want to call it blind

screening, or bulk screening of individuals using x-rays is inappropriate, but it should be on an individual determination by a physician or unless it's guidance from appropriate medical -- what did we call ACR or --

RANDY SCHENKMAN, CHAIRPERSON: Societies.

CLARK ELDREDGE: Society.

MARK SEDDON: Society. ALA or American Lung Association. Because the ALA, they have that 30 pack a year history.

CLARK ELDREDGE: Something like that, yeah.

MARK SEDDON: Yeah. Age 55 to 80, 30 pack a year history of smoking and are a current smoker, or quit within the last 15 years, you are eligible for the initial cancer screening.

CLARK ELDREDGE: So those would be, you know, the appropriate uses. And actually put in a prohibition against screening unless, again, if your doctor figures, I'm not about to say any doctor thinks everybody, you know, that anybody at a certain condition in their care should certainly have certain screenings. That's within their professional judgment, but --

RANDY SCHENKMAN, CHAIRPERSON: Then they go some place with a prescription, which is the

doctor's approval of the doctor's order of having this done. They aren't just walking in and getting it done.

CLARK ELDREDGE: Right. Well, other than -- well, there's the approval, right. But the physician shouldn't even, you know, we need to tighten up that a physician isn't selling his signature. Because let's, you know, let's be honest. That's what was happening with the opioid crisis. Physicians were selling their signatures and so we have physicians selling signatures without any due cause or evaluation or using it in treatment of their patients.

MARK SEDDON: I think a lot of the restrictions with ALA. Those are all for reimbursement for Medicare; that kind of stuff. So I think it's self-pay.

CLARK ELDREDGE: These are all self-pay.

MARK SEDDON: That's where you might be having all the --

ADAM WEAVER: Insurance companies won't approve it.

MARK SEDDON: Yeah, insurance companies have strict standards and there's where you have --

RANDY SCHENKMAN: Right.

NICHOLAS PLAXTON, M.D.: The VA, so we have the -- we've instituted this low dose chest x-ray -- or not chest x-ray. CT for our patients that have that history. So the doctors will be aware of that and they order them. I mean, usually you're into a grab bag of, they usually end up having all kinds of issues. They have nodules. Now they get a PET/CT. They have a work up. Things are getting cut out. It's not lightly, you know, you go into that. There's a, you know, after 30 packs a year of smoking, you're going to have something. So your lungs look like Swiss cheese. You're going to have nodules.

But that -- I don't see how that applies to like, it sounds like these are just people that are paranoid and they want to get a whole body scan to kind of keep an update on themselves. They want to pay cash. They don't want a doctor involved at all, right?

CLARK ELDREDGE: Right.

NICHOLAS PLAXTON, M.D.: That's the whole idea. But I think, I mean, is that even allowed or are they allowed to do that?

CLARK ELDREDGE: Well, but there's a doctor who's, again, signing the scripts.

NICHOLAS PLAXTON, M.D.: Someone is signing?

CLARK ELDREDGE: Someone signing them sight unseen. Just approving them.

NICHOLAS PLAXTON, M.D.: You've got to find out who those doctors are, I would think --

MATTHEW WALSER: There's no patient/physician relationship.

CLARK ELDREDGE: There's no established patient/physician relationship.

NICHOLAS PLAXTON, M.D.: Those doctors --

MATTHEW WALSER: They should be reprimanded.

NICHOLAS PLAXTON, M.D.: They should be reprimanded for their actions. If you could find out who those doctors are.

CLARK ELDREDGE: When we visited the spot, we did it with MqA. So they're currently --

NICHOLAS PLAXTON, M.D.: Involved.

CLARK ELDREDGE: -- involved.

MATTHEW WALSER: Were they in-state doctors, like in the State of Florida?

CLARK ELDREDGE: Yes. As I said, the DEXA guy was out of state. The CT scan is in state. All of them are state licensed.

KATHLEEN DROTAR, Ph.D.: If I wanted to have that type of scan, then I could just go in and say,

I'm, you know, I'm self-pay and, yeah, I've been smoking for 30 years. And nobody is going to check, just go through and check off on a list and, okay, now you qualify. You can go have it done.

NICHOLAS PLAXTON, M.D.: If you're going to do it live, that would be a chest x-ray, not a whole body CT.

KATHLEEN DROTAR, Ph.D.: Well, people walk in for anything that's free and now I can get it checked, you know. And the oversight --

NICHOLAS PLAXTON, M.D.: Yeah.

KATHLEEN DROTAR, Ph.D.: -- needs to be there.

ADAM WEAVER: If you're self-paying, they're not going to turn you away.

KATHLEEN DROTAR, Ph.D.: Yeah. Here's my money.

NICHOLAS PLAXTON, M.D.: Yeah.

RANDY SCHENKMAN, CHAIRPERSON: And you have one more category here?

CLARK ELDREDGE: Our friends at the Department of Corrections have submitted a request to, request use of technology on all persons entering and exiting the secure perimeter.

So this is a transmission x-ray security scanner. This is currently permitted under

administrative code, although this is not actually one of the uses recognized in the Florida Statute. But under Florida Statutes, we do have the, sort of the responsibility for use, expanding the safe use of radiation or making sure, not restricting anything.

But the previous thing is actually for looking for contraband hidden inside the digestive tract is the purpose of this. They want to expand it to everybody, whether or not there is any real risk of them smuggling anything in the digestive tract.

We have -- our current draft response is explaining that the reason we approved it was for somebody who would have the opportunity to bring something into a jail and be in there unsupervised enough they could remove it from their digestive tract to have contraband enter the facility in that manner and there's all their technologies out there you could use for quick screening of individuals with things hidden on their persons, not in their persons, such as the millimeter wave systems and/or the backscatter x-rays that they could certainly look at requesting or using. The millimeter has no effect outside of regulation. The backscatter would be up to our regulation purview; and that therefore,

we do not think this is appropriate use.

Plus, things like they don't -- they're not, do not state what the secure perimeter is. Is that the fence around the outside of the jail? Is that the most inner, you know, behind multiple locked levels of where the inmates are kept? At what point do they determine that?

They don't say anything again about here about the opportunity for supervised or unsupervised time inside their perimeter. And why would they need to use this on somebody who is, you know, if somebody is going to the day room to visit somebody, how are they supposed to be able to extract somebody, something from their digestive track to pass off to an inmate and then smuggle back through the rest of the facility. How would that transaction happen?

ADAM WEAVER: What kind of -- is this a fluoroscopic x-ray or what kind of --

CLARK ELDREDGE: No. It's a scanning x-ray. They're operated similar to like a DEXA machine. I mean, it's a single energy, but it's a pencil beam or fan beam that goes across the person or if they sit on a tray, they transfer in front of them with a scepter behind them. It builds up a fairly explicit image of their body or clear image of their body

through that.

ANSI does have a standard for this. How many times somebody should be exposed to it; that type of thing in here.

ADAM WEAVER: Is that where they -- this letter got 1,000 scans per year?

CLARK ELDREDGE: Yeah. By the way, at the low dose, which really doesn't show clearly what's hidden in the colon or elsewhere in the digestive tract. You really can't -- that's the thousand. And if you bump it up to the energy, when you look at the sample images provided by the manufacturer and you really want to see what's any sort of close, something, something similar to human tissue density that might be in there, you know, you do need a higher dose rate. And you get dropped down to like, you know, 50, I think scans a year, something like that, at those rates at the higher energy.

ADAM WEAVER: These machines have a fixed kV. I mean, or does the operator adjust the kV and the mA to -- for the image or does it just -- is it automatic?

CLARK ELDREDGE: It's -- I believe they're fixed. And -- but it's some sort of automatic, adjustable exposure control.

ADAM WEAVER: So they're time based rather than, okay.

CLARK ELDREDGE: Mm-hmm. But I can't be a hundred per sure. I can't remember off the top of my --

ADAM WEAVER: I'm wondering how are they --

CYNTHIA BECKER: How they adjust.

ADAM WEAVER: -- determining between low dose, medium dose, high dose.

JAMES FUTCH: Clark, wasn't there a component of this -- I remember reading the standard when this first came up, at those higher levels, they're supposed to track.

CLARK ELDREDGE: There's a requirement, they track all exposure. They also did not address this because we told them if you're talking about people, but if you've got some of your -- but if you're unfortunate to have family members in multiple facilities, incarcerated multiple locations in the state, or if you're a member -- an officer of the court going in to visit multiple people in different facilities in the State, they need to track that across those -- they need to have a system to track their exposure across all those facilities.

ADAM WEAVER: This isn't just for inmates.

This is also for visitors, perhaps.

CLARK ELDREDGE: This proposal is for anybody crossing the line. Then again, the question is, how much.

RANDY SCHENKMAN, CHAIRPERSON: Children and pregnant women.

CLARK ELDREDGE: Children, pregnant women. Well, in the second page, it says pregnant individuals.

RANDY SCHENKMAN, CHAIRPERSON: Yeah, it has a limitation, but then what does that mean? Once they hit that, they can't go visit the person anymore?

CLARK ELDREDGE: They also say no scans will be performed, but below that case-by-case consideration would be determined by duty shift supervisor or higher authority. Indicating that maybe will they or won't they? Because it's unclear from this special considerations whether or not they are truly not going to scan minor children or pregnant individuals.

KATHLEEN DROTAR, Ph.D.: How do they adjust the dose?

NICHOLAS PLAXTON, M.D.: From just reading that, it sounds like to me they would be like the airport where they you would get a, you know,

old-fashioned pat down and not the x-ray machine.

CLARK ELDREDGE: Yeah. Which is --

NICHOLAS PLAXTON, M.D.: Of course, that doesn't, you can't, you know, I guess they could have something -- they swallowed something. There's no way to find that.

CLARK ELDREDGE: Right. The same point, if you swallow something, you have to have the opportunity to expel it. In order, again, that requires you to be unsupervised in there for some extended period, you know, in order to --

NICHOLAS PLAXTON, M.D.: Yeah. People must be doing it because this seems to be a problem.

CLARK ELDREDGE: Well, again, I do not believe that that's the -- even though they list huge -- in their paperwork, they talked about how many contraband recoveries. They did not split it between hidden on the person versus hidden inside the person and that's not clear in any of their statistics of, you know; therefore, again, you don't need transmission x-rays to look for things hidden on a person. And so you don't need to be exposing those individuals to those.

And then as I say, the health and safety idea here, who's truly exposed to the risk of -- from the

benefit, risk benefit, if the individual, you know -- what am I trying to say here?

Somebody going in to visit a loved one in the day room, so to speak. What risk are they from the drugs and stuff that maybe actually inmates are taking behind the security, inside behind the next level interior, security. Or the shives, weapons and things like that.

So if you're x-raying these people coming in who aren't necessarily themselves exposed to the danger of the things at the next layer in, are you -- why is this, you know, you're giving them an exposure to a known carcinogen for what personal health benefit for them? Or life safety benefit, you know, is for transmission x-ray. So, you know.

NICHOLAS PLAXTON, M.D.: Are they using the millimeter wave or the backscatter right now or --

CLARK ELDREDGE: No, they are just using -- because the whole trick is what's hidden in the inmates' colons.

NICHOLAS PLAXTON, M.D.: They don't have those others instituted at all?

CLARK ELDREDGE: No. They just want -- you can also consider if there's a fiduciary consideration here, monetary consideration of the fact that that

would require more -- another piece of equipment, so they want to multi-use the piece of equipment, whether or not it's appropriate to do that.

JAMES FUTCH: Would they use the transmission machine in all situations, when backscatter would be, would've been acceptable for --

CLARK ELDREDGE: Yeah, would've done the equivalent. That's just -- they want to use the transmission for all purposes, for any search, they are going to use the transmission. That's the whole point.

ADAM WEAVER: These machines are smaller, less you know, less expensive to run.

JAMES FUTCH: Yeah.

ADAM WEAVER: The backscatter machines, computer, detectors, they always have to calibrate it, align -- there's a lot of expense. These are relatively simple machines. The operator, you know, it's pretty easy to use on your screen. You just see a picture. It's like the DEXA scan without the dual energy.

RANDY SCHENKMAN, CHAIRPERSON: So where does the State stand with this right now?

CLARK ELDREDGE: The current response is that it's, you know, if you're exposing an individual

without any benefit to a carcinogen, without any benefit to the individual for security purposes is not appropriate. That the individual should be receiving some sort of medical or life safety benefit to the exposure. And so they need to show us how that's supposed to occur.

NICHOLAS PLAXTON, M.D.: It sounds like couldn't they do -- I mean, the visitors coming in, can do like the backscatter technology or something of that nature? Where it sounds like the inmates are the ones that -- I mean, after they meet with the people, they could be going through one of these scanners because that does benefit them because like, you know, whatever comes across that line can be used against them or, you know.

CLARK ELDREDGE: Yeah, it could be either way against them, you know.

NICHOLAS PLAXTON, M.D.: That's what I'm saying. They could use the scanner for the inmates but not for the visitors. That would make more sense.

CYNTHIA BECKER: Right. That's why we approved that part of the revised regulation but not for the visitors or the employees. But I think from their standpoint, they're saying that the contraband is

getting into their facility through the visitors and through their employees. So that, I think, is where they're coming from.

CLARK ELDREDGE: Again, they did not say what categories of contraband.

CYNTHIA BECKER: Right.

CLARK ELDREDGE: I have -- hearsay is terrible, but this was third-party story through the grapevine. We do have an individual at the Department of Health who did, who has worked in the --

ADAM WEAVER: Corrections.

CLARK ELDREDGE: -- corrections and talked -- has told stories to someone else in our program about, you know, people hiding a piece of wire or piece of metal, but that's on their person. And when they go into the visiting room whatever, give a hug and the person is able to swipe it and transfer to their body a piece of plastic, but it could be fashioned into, again, some sort of weapon or thing inside. But, you know, again, that doesn't address what's the best use of these body scanners for this type.

RANDY SCHENKMAN, CHAIRPERSON: Right.

CLARK ELDREDGE: -- for checking what's hidden

in the digestive tract. Again, I don't quite see how in many of these persons, how they're able to extract something from their digestive tract and transfer it to another person, to then --

ADAM WEAVER: Mm-hmm. So you've asked for more information?

CLARK ELDREDGE: Yeah. Well, we've said no unless, you know, but it is a clarifying yes. You know, what's the --

ADAM WEAVER: You want more clarification.

CLARK ELDREDGE: You've got to demonstrate how it's benefiting the individuals that would be exposed to it and why they actually need it as opposed to other less intrusive or less -- the other methodologies that are just as effective that do not carry the carcinogenic risk.

We've been going on, and so that was actually the last item on my list of --

RANDY SCHENKMAN, CHAIRPERSON: Okay. So are we ready to break for lunch?

BRENDA ANDREWS: So we're suggesting to do what we did last year. Just go over to the World of Beer and it's right here on the complex. Unless someone else wants to do something different.

CLARK ELDREDGE: For the Record, that is a

restaurant?

RANDY SCHENKMAN, CHAIRPERSON: Yes.

ADAM WEAVER: Do they serve food?

BRENDA ANDREWS: They have lots of food.

CLARK ELDREDGE: It's the only restaurant within easy walking distance other than the one in the hotel here.

ADAM WEAVER: Okay. Be back at 1:30?

RANDY SCHENKMAN, CHAIRPERSON: 1:30. Yep.

(Proceedings recessed at 12:18 p.m.)

(Proceedings resumed at 2:02 p.m.)

RANDY SCHENKMAN, CHAIRPERSON: So, Kathy?

KATHLEEN DROTAR, Ph.D.: James, are you going to start?

JAMES FUTCH: Yeah. So let me throw in my two cents since I have -- Kathy sent me some correspondence, which is the essence of this e-mail that I sent to several of you asking to check with your facilities. But AAPM in April, issued a position statement which essentially says gonadal shielding should not routinely be used, again, due to some technical and scientific reasons which we couldn't go into. We have Mark here to explain some of that.

And then ACR agreed with AAPM, essentially,

which is the second letter. We have all these documents for anybody who hasn't seen them. Then ASRT said, whoa, we don't think we need to move that fast. We need to pay some more attention to the educational community in the timeframe she was there in the patient side of whether or not this is -- even if it's scientifically a hundred percent accurate, we have to implement this. We have to implement this in the patients in the real world and teaching of rad techs and things like this. And so AAPM, after the ASRT lack of endorsement, sent an open letter to the community essentially saying -- these are all my words, my interpretation of it, not Kathy's, essentially saying, well, you know, this is the scientific basis. We think this is correct, but we never intended this to be the be all end all. This is a start of a dialogue with the community and we need to hear from all aspects of the stakeholders and they formed this CARES community to go forward with that.

After we talked, Kathy and I put this together and sent it to various members, many of whom responded either verbally or in the case of Miss Becky, actually put the PowerPoint presentation together and queried many members of her own

facility and surrounding facilities and we have that also back here to talk about as we work all this together.

So is that good? Bounce it back to you.

KATHLEEN DROTAR, Ph.D.: Yes. Thank you. The little packet you have sort of has that correspondence as it evolved. And I don't know that anybody outside of physicists really saw anything until ACR then endorsed the position statement and then everything sort of started blossoming. And the -- one of the things I wanted to point out was that there are -- with the original position statement, there's several good reference articles that are in support of those statements for the position statement.

But what happened was that at the -- they immediately had a facility who said, no more shielding. So that sent up a red flag for us because, you know, there's State regulations that include shielding and specifically don't add on fetal shielding. So that was a start of a conversation with James and I.

I attended the ASRT annual meeting and at the House of Delegates -- well, actually one of the first things that happened was that Dr. Sal Martino,

the president of ASRT, got up and said, "Everybody calm down. We're going to look at this. We're going to be part of a community with AAPM. We're going to find out because it not only affects what technologists do, it affects what our educational components are." That's just ASRT.

ARRT, with the examination and certification, it's also, you know, whether the proper, proper radiation safety and, you know, how do we address these things. So it's more of ASRT, ARRT wanted to take a position of what are we saying and, you know, have some protocols for, you know, the best way to do this.

And at the ASRT meeting, you know, technologists had been, you know, shielding from the time that I was a student that, you know, this is what you do. You do shielding. And now it's like, oh, it's okay not to do it.

The AAPM Article Two by Dr. Whitemarsh, stated at the end of the article, that it should be up to the technologist because they are the person that can better define what they should do in that particular instance. Also, that the patients are used to being shielded. Patients don't want to -- you know, they want to know that they're safe and

they, you know, they've been indoctrinated also with, you know, shield me.

And so there's a lot of questions I think to be answered. And the CARES community is one that, that Mark's familiar with. And as far as we know, they have -- they're still gathering people. The people that want to weigh in.

One of the things in Dr. Whitemarsh's article was a compilation, I think, of several different things, but I think the dose without shielding was .08 mR to .009 mSv, which was the protection that, you know, is a very small, very minimal dose. But the intent of the article, though, was that it's not the external shielding that's necessary because it's really the internal radiation risk that is more of a question and that the shielding doesn't stop that. So --

MARK SEDDON: Right. So a little more background. So this is an initial start because there's some states in the country that have requirements stating that you have to have shielding available for patients. And so for years, especially in some -- in the OR and CT areas, a lot of times you don't shield and it's kind of an accepted thing with physicists and the industry,

certain areas you don't shield patients in those cases.

So I think it was -- they were having some conversation with the regulatory folks somewhere in one state and they wanted to actually have an official position statement from somebody to say, let's make this more official rather than kind of word of mouth where you don't have to shield in every case. You don't have to have shielding in every case. That's kind of where that came from. That is what drove the AAPM or to consider putting together the position statement that came out in the spring. And it was discussed quite a bit and basically, as Kathy was saying, the feeling was there's no real -- there's no actual -- the amount of dose you get from radiation imaging is, in the diagnostic world, is minimal. As below the levels where you have some type of an effect, gonadal effect on patients. The actual effectiveness of the dose, as you're saying, is real little because of the majority of scatter within the gonads is from internal. If you're actually going to be direct shielding the gonads, in a lot of cases, that's within the image. If you're actually putting shields within the image, you're obscuring the image

and causing a problem.

So the theory is that whatever is causing the benefit could be potentially causing a problem if you place the shields in the way. So that's kind of the recommendation from the position statement.

KATHLEEN DROTAR, Ph.D.: Yeah. It was also that with the digital equipment, that putting the shielding close to the field would then throw off the automatic exposure and you would actually be significantly increasing --

MARK SEDDON: Increasing the dose. And also for digital equipment, a lot of times, even if it doesn't affect the dose, it fully affects post processing because all that effects -- because those who work with DR or CR, combination, it makes a difference. You could be adversely affecting the quality and having forced repeats. A lot of those reasons go into why the statement came out.

As Kathy pointed out, a lot of people are involved in changing a lot of different practices across the board. So I think that's where the CARES committee, which is, in essence, a committee formed -- the acronym is like something just to make it sound like cares. So it makes up the word cares. But it's basically, I can't remember what it's

called. It's a committee that includes, like, ACR, AAPM, HPS, ASRT, NCRP, CRCPD. To go ahead and be part of the group discussion on how to best roll this out.

And really, the focus from the CARES committee is to try to educate because I think the feeling is, we have a position statement so it's official from some of the -- even in here I believe it states like the ACR, HPS, AAPM, you know, all the other organizations, they all have endorsed this as this is the consensus and feeling within the community and how to roll it out is really the question. How to roll this out. This is what people are aware of and how do we roll this out regulatory wise. How do you roll it out. CRCPD is looking at this; NCRP is looking at this.

KATHLEEN DROTAR, Ph.D.: NCRP, yeah. And it's Communicating Advances in Radiation Education for Shielding is what the CARES committee is.

So there was also a study that was done as part of that, part of one of the reference articles of the facilities in England, over 500 cases in a retrospective study. And almost every -- it was over a third of them were repeats because of the shielding being incorrectly placed. So that was

another significant reason, I think.

MARK SEDDON: You guys might recall there was a big push for patients getting mammograms done a few years ago to use thyroid shields. Do you remember that?

KATHLEEN DROTAR, Ph.D.: Yes.

MARK SEDDON: A certain doctor on a certain T.V. show recommended it on cable T.V. so everyone came, wanted to go have thyroshields. They started using thyroshields. They are right here and all it takes is for them to drop a little bit. Now suddenly you're obscuring and having all the repeats. So like, really in scatter mammography is minimal. Nothing to the thyroid, in essence.

So one of the concepts we've used in the past even, it may not be a real benefit to the patient, but provides piece of mind. So you give them an apron and they feel safer even though it doesn't hurt anything. So if it's not hurting anything, then it's okay. But we're now seeing that in some cases, it does hurt things. So that's where I believe the push is coming to try to change the practice.

JAMES FUTCH: This is the section of Clark's regulation that speaks to gonadal shields. And

essentially, everything says you're supposed to use them except for this last little clause right here: Except for cases in which this would interfere with the diagnostic procedure.

And then Cindy or Clark, I forget which one of you guys provided this, the notes from the --

CLARK ELDREDGE: CRCPD.

CYNTHIA BECKER: Yes.

JAMES FUTCH: -- the CRCPD, which is this one here.

CYNTHIA BECKER: Yes.

JAMES FUTCH: So this is -- so this is a conference call from September 3rd. So all the states that have x-ray regs probably adopted them from the suggested state regulations, at least when they started and then modified from there. So there's a commonality to the states' x-ray regs. And so there's questions on how to handle a gonadal shield from AAPM and you saw the states before that are participating. You can read it for yourself.

KATHLEEN DROTAR, Ph.D.: That was a big question with ASRT, what about state regulations, you know. Are we teaching our students to do something that is not acceptable by state and federal regulations.

REBECCA McFADDEN: Well, I think it's kind of open ended. It says if it isn't going to obscure your exam, that kind of gives you that ability to educate it in that manner, at this point, but, you know, looking forward, you know, they're looking to make that change.

KATHLEEN DROTAR, Ph.D.: But there was several comments from different program directors and doctors from different states whose facilities had done the same thing that ours had and said, no more shielding. So that's a difference when you get into those gray areas.

REBECCA McFADDEN: Mm-hmm.

JAMES FUTCH: So it seems like we're dealing with a situation which would normally, from a scientific basis, if we started out this way, we probably never would have done the requirement to begin with if we had the same equipment that we have now. But you have an installed base of both machine operators and more importantly, the public and their understanding and natural fears of radiation in general to deal with.

And I don't know if any other members want to jump in or if you want to, Becky, if you want to show them the PowerPoint.

CYNTHIA BECKER: Sure. Do you have it on your --

JAMES FUTCH: Yeah. I'll get it up.

REBECCA McFADDEN: So when I was asked, my entity, to reach out to some of my colleagues in the area. I just picked 20 people that I thought that, you know, would be interested in reading the information and providing me with some feedback. So this is basically just a breakdown of the statement, which you guys have already read that, which is what I provided to them. Also just giving us a brief look at what the acronyms are because it does mention those several times, so for me, I had to go and look and make sure I understood what all these things were. So I just listed the agencies.

And then some of the feedback, basically, this is just the timeline. In April 2019 is when the AAPM released the position statement and then on May 30th, the ACR agreed with it. I just highlighted the medical physicists and quality and safety, they're going to be reviewing it in order to make recommendations for alignment with the position statement.

Then in July, more research was required by the ASRT because they didn't feel comfortable

recommending the discontinuation of the patient gonadal shielding and there was some more general information about the ASRT, but I just kind of highlighted that piece. Like, okay, hold on. That's where they put the brakes on.

In August, the ASRT Board of Directors said cannot endorse the proposal at that time and that there were numerous questions and possible change.

And now moving forward, this is -- so the information that you saw in the first slide was what I provided to some of my colleagues in education, in management and actual patient, just to kind of get an idea what their thoughts are.

So this was an HCA hospital. She's the manager. She works strictly under the director. Her contracted physicist group endorses the statement and they have already begun changing their policies to reflect that. So she's in the north central region of HCA. So that's one of our supports.

Next we had a not supported. This is a person who actually provided me with a story about his child had -- he was born clubfoot and he had multiple, multiple x-rays. And as a result of that, he's not sure there was never no evidence, but he

felt that it was part of that could've been -- I guess he died of a bone cancer later on and he felt that that could have then contributed to that later in life and he did die at age 20.

So -- and he is a physics instructor. He just teaches the physics class and he is a radiographer and he said he was -- until that time, he was going to continue to use the shields. To teach his students to shield. So he was very adamant of, you know, because of that personal situation. He was adamant not supported.

The next respondent was that they had agreed. This an out-patient, multi-clinic supervisor, so she does CT as well as supervise. I think there's seven or eight different outpatient facilities that they have CT in. And so, one of those questions that she said, you know, that they agreed. They implemented the new. They no longer shield the patients.

But then the question is -- and I wanted to ask your opinion on this, Mark -- with the CTs and the shielding. That's always been kind of hard for me being that CT was my background. We were told to wrap them front and back. Then we were told not to do anything. Then to do the top and then to do the bottom. I mean, it's always been such a variable.

I don't know what the recommendation is in the medical community for that or what it is regarding CT, but this was really just talking about diagnostic imaging, so I did want to ask that question.

MARK SEDDON: So CT is the same thing.

REBECCA McFADDEN: Same thing. Okay.

MARK SEDDON: I'd say probably the consensus to not provide CT has been longer within the community. Primarily just because it's --

REBECCA McFADDEN: It obscures all --

MARK SEDDON: Obscures -- it can really mess up your -- the new CRT scans have dose modulation.

REBECCA McFADDEN: Right.

MARK SEDDON: But the only time if it's out of field, and then in, you know, we still have some places like -- well, especially, if it's specifically requested by the patient for peace of mind because they're used to it and I think that's what I say a lot of times people still shield, it doesn't hurt. The whole thing about the bouncing ball inside the scatter tank, that doesn't really exist. In compass scatter, you already scattered the radiation to the point, it's not going to scatter back.

REBECCA McFADDEN: Right. So it's not going to -- like she was saying.

MARK SEDDON: Right. This is like low energy you're talking about, yes. So that's not accurate, yeah, because there used to be some --

REBECCA McFADDEN: These are their personal responses, so I'm sure --

MARK SEDDON: That's not accurate, but I mean, you know, that's been, I think it's seasonal, longer been more discussed in the past.

Now, I will say that there has been for a while for CT, you know, in plain shielding, business shielding with the eyes and breast to reduce, that's actually, it's not like the same as a lead shield. It's actually business shielding, which is actually intended to be scanned through. So it reduces the dose to the body part. That's a different type of shielding than which we're talking about here, which is gonadal shielding. It's a piece of lead actually completely stopping the radiation.

REBECCA McFADDEN: Okay. So that was the response there and then discussion on the CT.

So this is a director of imaging services from a hospital, obviously talking about the CR versus the CT and the same question about never using the

shielding and the wrap, so we're all kind of coming from the same place. But at the end of the day, we all have our own personal professional feelings.

So his is basically the same. He started talking about the reducing of different, you know, with the lead and using non-medic exposures, the gonadal apron's importance is outweighing the benefits versus the risk.

So he basically concluded by saying in a perfect digital world, what they are suggesting makes sense. But as a side note, we recently conducted a research inquiry on the uses of lead wrap shields associated with CT and it was proven that you should never shield the patient with a CT scanner due to the scatter bouncing between the lead shields internal to the patient. They don't have their friends like Mark to explain that to us the right way.

But he said, but in the -- I think in their case isn't quite proven considering the facts, and that there are many older technologies and CR machines still in use today.

So having that being said, you know, there are variances of machines and when we heard how many there are out there, and if they're using the

technology that we all are using in some of the larger hospitals.

So he was a not supported. I felt like from his, you know, back and forth a little bit, I felt like it was a not supported.

And then another one, they disagreed. That this patient should be -- this is another educator. Clinical coordinator. One of the large schools. Shouldn't shield the exams. They felt like that it, you know, again, I think the education portion of it, that clinical coordinators, they're so, you know, used to educating that and they don't want to change that practice, you know, at least from my observation and what I've pulled.

My next, conclusion, is basically it was a split decision. I had twenty people I surveyed; I got six responses. And it was 50/50 of supported and not supported, which then justifies it, it is going on the table for some discussion and some collaboration, but I think the collaboration, I agree, Mark, is about how we're going to educate the community, the people who are utilizing these practices and not just going to say, we're going to make this statement it's going to be the new rule. But it really has to be done in a different manner

and I think maybe even if they take it back to the table, it will get out and maybe, you know, the medical professional community in radiology will adopt and, you know, move forward with that.

MARK SEDDON: I think that was the intent. The initial position statement was more to say it's not recommended anymore. And they recommended that discontinue use, but not like an official, this is now effective April 15th, you have to stop shielding.

REBECCA McFADDEN: Yeah. Like no -- you can't even sell a gonadal shield. I don't think that's where we're at.

MARK SEDDON: This is position statement that people use to justify whether to decide --

REBECCA McFADDEN: They are or they aren't.

KATHLEEN DROTAR, Ph.D.: I think the flip side of that, I was thinking during all this discussion was going on, was time for they couldn't shield because it wouldn't have been appropriate to shield, so it was like, okay. That was already done, you know. That if you shield or don't shield, if you're doing it properly, then it's okay, too. It may be okay depending on the equipment, but certainly needs to be looked at. And everything I think is going to

come down, it's going to start with the physicists, it goes to the radiologists and then comes down to the rest of us. That's the way that things usually work. Because then the think tanks are there to really investigate it and to see what should be done.

MARK SEDDON: Yeah. I think one of the things would be, because part of the data out there would be, how many times do you have repeats or studies compromised because of the fact that shielding is in place.

REBECCA McFADDEN: Right.

MARK SEDDON: Does anyone really look at that from -- in the imaging radiology world? I don't think -- that's not real something honestly --

REBECCA McFADDEN: Repeats are difficult to track as it is.

MARK SEDDON: Right.

REBECCA McFADDEN: I mean, I think we've had conversations about that.

MARK SEDDON: Yes.

REBECCA McFADDEN: And with the equipment and the digital world, I mean, we, of course, give you software for a nice little fee to pull your repeats, but that doesn't -- it's not like the physical

marker on the image we used to count back in the days, you know, to see who's actually repeating this.

MARK SEDDON: I think historically, people in a lot of places have said, you know, I don't feel -- I don't have to shield because I don't feel it's a big benefit. But I may still shield because it makes the patient feel more comfortable. It sounds like some of the people educating, even the query, that was the kind of the thing was like as a patient, I feel more comfortable with my child being shielded.

REBECCA McFADDEN: And I think the statement did cover that and said that it wouldn't be questioned. I mean, you can still do that or you can still shield. It's just we think that --

MARK SEDDON: We don't think it's a requirement.

REBECCA McFADDEN: A requirement, right.

MARK SEDDON: I think it's really -- the wording maybe could've been a little bit better.

KATHLEEN DROTAR, Ph.D.: I think the second letter that got sent out --

MARK SEDDON: Actually clarifies better.

KATHLEEN DROTAR, Ph.D.: Yeah, it's a lot clearer.

JAMES FUTCH: Since Mark Wroblewski isn't here, he actually sent me an e-mail. Let me just read that. Can you all read that? I'm sorry.

Anyway, it says, he heard a little bit about this. He said their position -- he runs a clinic or a couple clinics. He's also a basic machine operator. He says, "our position has always been safety first. We saw no reason to not shield them and not interfere with the exam."

The second position has been to try assuage new patient expectations. Mom and dad don't know who the AAPM is, but have been told for years radiation is bad, use shields when available. Until I have overwhelming evidence that we shouldn't, I see no reason to open the door. We get the x-ray, mom and dad are happy and we've done more than the minimum."

So he fits into the category of folks that you surveyed.

REBECCA McFADDEN: Mm-hmm.

JAMES FUTCH: It's interesting to me to see AAPM putting the statement out and then so many members of the radiation community and various levels in fairly high positions having such divergent viewpoints on this. Imagine what the public is going to think. This one is going to go

on the news.

REBECCA McFADDEN: I think our point is our physicists and our recommendations and they are basically our final go to's.

KATHLEEN DROTAR, Ph.D.: Oh, absolutely.

REBECCA McFADDEN: And so, in my opinion, you know, in 31 years I've been in radiography, I mean, it always comes down to what does the physicists require, request or need and that's how we operate. Because they have that, that profession and knowledge to tell us what is the best thing or best practice, in my opinion.

RANDY SCHENKMAN, CHAIRPERSON: It seems like it's a problem with education.

MARK SEDDON: Yes.

RANDY SCHENKMAN, CHAIRPERSON: That's what it is across the board for everybody.

REBECCA McFADDEN: Right. It's education everywhere, yeah.

RANDY SCHENKMAN, CHAIRPERSON: For the physicians, for patients, for the techs, it's going to be education that's going to, you know, decide which way this is going to go. When people are educated, they will say, okay, fine. I don't need it. And actually, could be worse for me as opposed

to what they've always been taught up until now, which is you've got to protect these areas. You know, it's a different philosophy, but it's based on education.

REBECCA McFADDEN: And it's based on the equipment changes and how we are acquiring our imaging now versus what we did years ago --

RANDY SCHENKMAN, CHAIRPERSON: Right.

REBECCA McFADDEN: -- when those parameters were put into place.

MARK SEDDON: I think it's interesting that all the physics organizations and most of the physician organizations are in agreement or endorsing. The folks that actually work with the patients are the ones who are aware that this is going to be a problem because we're the ones that actually see, you know, the technologists and the educators. They know what the patients, what their logic is and how it's going to cause trouble.

JAMES FUTCH: If you have a parent who decides not to have the image taken --

MARK SEDDON: Exactly.

JAMES FUTCH: -- because they don't want it taken without some sort of a shield, then that's not good, either.

MARK SEDDON: Exactly.

JAMES FUTCH: So I don't know if anybody else had any input they want to provide Mark from --

MATTHEW WALSER: I talked to several people over in the UF Health system. Some rad techs and radiologists. Interestingly, there were two people that didn't know anything about all of this business.

JAMES FUTCH: The director and assistant director?

(Laughter).

MATTHEW WALSER: They will remain nameless. I did forward them the articles and they read them and got back to me.

But pretty much after a big discussion, everybody said -- there's actually a policy to shield at UF Health and you know what it's like to change policy. So right now, it is a policy to shield unless it is interruptive of the exam. So pretty much they said, if we're doing -- I didn't get into the CT world, but just regular x-ray technology -- that they said if we're doing a hip or a pelvis, we don't shield and everything else we shield.

So they, you know, at one point, they were

trying to shield one side to get the lateral on the other. And they said that they were -- that this was a while ago. That they would end up having to repeat and that was way worse than just not shielding. So if it's not a hip or a pelvis, they're pretty much shielding.

KATHLEEN DROTAR, Ph.D.: I thought that I was going to go back and find historic documents and -- because we shielded. And, you know, it's like, you know, knowing that you push the exposure button, you know, that you shield. And I could find nothing anywhere except maybe some textbooks about how to shield. Until I got to about 2008, and then it was AAPM articles that questioned whether we should be shielding or not when it wasn't necessary in certain instances. So it's --

REBECCA McFADDEN: Maybe that was the automatic exposure control era. Because they were all fixed techniques and then when you get your AACs and you're starting to use lead again, if you're off center, your exposure is going to increase. And that -- the automatic exposures came out probably late 70s, early 80s, right? Like around that time? Something like that.

KATHLEEN DROTAR, Ph.D.: Something like that.

So the consensus sort of from ASRT and what we had decided was, as students or educators and having students at facilities, you're their guest. So we would be going with the policies set forth by that facility. But still teaching our students, this is what you do. And, you know, because it's a part of their competencies because that's the way it's built, until something happens that the curriculum actually changes that, you know, real world.

JAMES FUTCH: So this is the current reg. and this is the way the reg.'s going to stay for now, I guess. Everybody seems to read this and think there's enough room for either position.

REBECCA McFADDEN: Yeah, I do.

ALBERT TINEO: That's, yeah.

JAMES FUTCH: That's always a good regulation.

ALBERT TINEO: You can adjust your policies to meet that requirement.

REBECCA McFADDEN: To meet that requirement.

ALBERT TINEO: You can go to the extreme or you can go right in the middle and still be okay.

JAMES FUTCH: I do remember seeing one sentence in that mountain of material, from which organization I don't remember. But it said, in April, the FDA announced that it would look at or

begin the process of removing the requirement to require shielding.

KATHLEEN DROTAR, Ph.D.: I think it's on the website, I believe.

ALBERT TINEO: It's interesting because not last time, but the time before when the Joint Commission came to review, I went -- when they go to radiology, I go to see what they're looking for and it was a pediatrician. They wanted to see x-ray images of a pediatric patient. And what he was looking for was the shield. So it's just a interesting perspective of --

REBECCA McFADDEN: Maybe he just wanted to see if you guys had it or not.

ALBERT TINEO: If we were shielding. But that was about two years ago, so -- or at least coming down in the area that you were looking for.

RANDY SCHENKMAN, CHAIRPERSON: Well, I wasn't able to reach too many people, but at the hospital that I had worked at, my understanding, just from talking to the radiation protection officer there, he said that they had not changed the shielding practices yet, but they were sort of waiting to see what the final outcome of the discussions, I think with the CARES committee, were going to turn out to

be before they changed their policies.

JAMES FUTCH: Okay. Anybody else? All right.

KATHLEEN DROTAR, Ph.D.: I just thought it would be important to bring the discussion here and have it here to get that input from everybody and, you know, I think we're here, you know. See what we see.

JAMES FUTCH: We certainly have all the documents and minutes and the conversation if anybody needs to use it for educating or referencing.

MARK SEDDON: I think, as you pointed out, the regulation allows flexibility. So that's probably the key take away.

KATHLEEN DROTAR, Ph.D.: Yes.

JAMES FUTCH: And if you hear anything more from the ASRT world, especially --

KATHLEEN DROTAR, Ph.D.: I was hoping they would have their meeting before this, but I don't think it's until later.

JAMES FUTCH: Okay. My turn again?

RANDY SCHENKMAN, CHAIRPERSON: Your turn.

JAMES FUTCH: Okay. Actually Cindy, you covered this one.

I just wanted to mention that Lynn Andresen,

who you saw at the last meeting or the meeting before, was here with Ginny and she has moved on to Kevin's section. She worked for me in 2005, 2006 in the rad tech program prior to MqA, so when she came back a couple years ago, it was kind of an eye-opening experience for her. Oh, wow, what's this MqA thing? She actually, if I remember right, Clark, she started working for your section.

CLARK ELDREDGE: She worked for me all of two weeks or something before she jumped back to work for you. I'm not sure what that says but --

(Laughter)

ALBERT TINEO: Nothing personal.

JAMES FUTCH: No. But she is, I can't say enough with her time, with us in my section. Excellent work. You want to talk about a person who burns the candle at both ends, her candle has four different ends. It's always going. She's working on her Master's in her spare time. I'm saying all these nice things because if I still need to borrow her occasionally --

(Laughter)

JAMES FUTCH: -- for certain things.

CLARK ELDREDGE: There is something coming up in two weeks --

JAMES FUTCH: I saw that we have another.

CLARK ELDREDGE: -- we have another medical event. No details yet. We got the call as we were leaving town yesterday. So --

JAMES FUTCH: Okay. Moving on. So this week, in fact, a couple days from now, Kelly Nesmith, who many of you know is the coordinator for the rad tech program, she's going to be traveling to Minneapolis and ARRT does this CE consensus meeting. They used to do this every couple years and then with all of the new changes and requirements for what do they call it? Continuous quality review, the CqR, you get to relicense yourself every ten years, there have been a lot of changes with continuing education. So now they're holding this meeting, it seems like every year, to kind of keep up with the volume of things that need to happen.

So what I wanted to say about this is that there many, many aspects of this that folks in the community don't realize go on. There are, I forget, seven or eight different states that approve continuing education for radiology, rad tech in some way, shape or form. There's several groups, societies, CE-approving organizations, and of course, there's ASRT, which has mountains and

mountains of CE and ARRT at the regulatory level which has its requirements for what you need to do to renew that license.

All of this, the goal of all of us is to not have CE, the one organization that says is really good and it's relevant to this matter and it's worth this many hours of effort. And another organization you go, oh, that's crap and it's worth nothing. You know, it should not happen like that, right? We should all be using the same standards and the same -- so this, this mechanism, I think, pre-dated me in this program and it is continued, and gotten more complicated as time goes on. So we as the State of Florida, appear, especially Kelly, the CE manager, go to do a couple different things.

So there are changes coming and there are changes that many of you are aware of. We've modified CE requirements in Florida to become, as I described it, more and more granular. We used to not approve things that are less than a hour. Then we didn't approve things less than a half an hour. Then they want us to approve things 15 minutes long in terms of length of time. Now with the rest of this, it's becoming subject matter specific. So if you were licensed by ARRT after January, July 2011,

whatever the date was, you're going to have to go through this requalification. In addition to renew your CE, you're going to have to start showing even more specific subject matter for the particular kind of license that you have.

That means that you have to actually have all that granularity out in the approving of the course, itself. It's not, oh, here's 16 hours worth of training at this conference and it's all in radiography.

I went to the whole meeting; I get 16 hours worth of credit. It's not like that anymore. So it's not really a battle, but where we're playing catch up because we're states and we have regulations and many other concerns, and ARRT, and some of the other groups are way out there in front changing things. And we're like, what? Why are we doing that? Okay.

So this is why we're voicing our opinions on how things are changing, how fast things are changing and trying to maintain that, that uniformity of, well, if it's approved here, it's going to get the same type of subject matter review and same number of hours for each of those by this other organization, some other part of the country.

So your tax dollars at work. Actually ARRT's because they pay for this to go out there and do the meeting.

But I just want to make sure that you were aware of that aspect of things.

Now, here's another one. The exam fees are going up. Surprise. No, they're not going down. Let's see here. So here's notification. So effective January 1st, 2020, the current fees are on the left. The fees on the right now, the way it works with our regulations and in Florida, they -- the person who applies to MqA pays us a $50 application fee that goes to the State of Florida. Once they're approved, we send their information to the national registry, and they give them information about how to register for the Prometric, Pierson View, whatever it is these days, testing at the test center and they have to pay this fee directly to ARRT.

So the fees on the left are what's on our website. Basically the basics, what they call limited scope is what we call basics. So the basics pay 125; everybody else pays 140. And effective January 1st, the basics are going to be paying 140 and everybody else is going to pay $35 more for just

the ARRT examination fee. Got that? Okay.

KATHLEEN DROTAR, Ph.D.: For Florida. For Florida licensing.

JAMES FUTCH: Yeah. I don't know, they're -- I'm assuming they're going to charge the same thing to the other states through contractors.

KATHLEEN DROTAR, Ph.D.: Yeah. Ours is applying directly with our students due to the ARRT, it's a $200 fee. And they need to renew their license by endorsement.

JAMES FUTCH: So on our website, we've had this up for, I think a month or two. And this is the new fees that you're seeing and there's a little footnote. I won't show you, but there's a footnote down at the bottom this says this is the fee effective January 1st, 2020.

You might ask, well, are we going to, mental note, 2020. It took a little bit of work to get this up here. Not going to have them change it at this point. I just wanted notice to be given out.

So there's notice on the website. There's notice through your members, through your societies, through your facilities. Everybody is aware now that the fees are going up.

This, by the way, this is an interesting aspect

of the statute. The statute is written so that we have regulatory control and authorization of what they pay us. The fee to the national organization for the testing is exempted from that. That's not covered. And does anybody else know of any other testing organization that might be providing all of these different things to --

KATHLEEN DROTAR, Ph.D.: Instead of paying ARRT? Is there such an animal?

JAMES FUTCH: The look on your face. Is there another?

KATHLEEN DROTAR, Ph.D.: There is no other.

JAMES FUTCH: I know. I know that.

KATHLEEN DROTAR, Ph.D.: That was funny, James.

JAMES FUTCH: I was just saying that so it's in the Record in case somebody up the chain of command looks at it.

All right.

REBECCA McFADDEN: Has there been any change in the application fee with the change in the national registries?

JAMES FUTCH: I'm glad you mentioned that. No.

REBECCA McFADDEN: Why?

KATHLEEN DROTAR, Ph.D.: It was changed about two --

JAMES FUTCH: We're at the caps for everything regarding radiologic technology -- I wish Janet was here -- for, what is it? 2019. I think twenty years at least. We are not at the cap in one particular area, which is the renewal fee to renew your license.

REBECCA McFADDEN: Right.

JAMES FUTCH: It's currently 55 for the first and 45 for the additional. The cap is 75. We just did our annual regulatory plan, which we do every year, which we tell the agency and everybody else, this is the areas of the rules we think we will be changing in the coming year or might need to change. And in that lovely document, there are sections that ask if we are covering our costs. Are we recovering what it costs to do this. And we are not in that one area.

We had a package -- help me with this. We had a package during the Crist administration, that -- and this council saw it, which would basically have increased the fees to the cap for renewal. So instead of paying 55 for one license, you pay 75. Most people when they look at that as licensed professionals go, wow, that's a great deal. Even at the higher level.

KATHLEEN DROTAR, Ph.D.: I know. And the advisory council at the time said that it was one -- it was still one of the least expensive licenses in the U.S.

JAMES FUTCH: Right. So that one was published as a proposed rule making. We received no adversarial comments.

In the process under Chapter 120, after all that, those two time periods expire, is you go back up through the agency and you get a sign off by the agency head and then it's posted as final and that's where it failed. I'm sorry. At that particular step.

And I had a very nice, personal conversation with people who are no longer with the agency, who said, after my 15-minute explanation of why we were doing this, that that is the most reasoned, well-evidenced, documented argument I've heard in a long time. You'd make a excellent case. However, we're not going to do rule changes this year, so we didn't. And for many years afterwards.

So it could be something that could be raised again and --

REBECCA McFADDEN: Would that raising provide any additional assistance for the office of

radiation control and all these different entities that we house? Would that provide any -- I mean, looking at the number of licensures that are out there, the impact is going to be, would it be minimal or -- like, if you raise the fees, you have X number of dollars within the budget brought in.

JAMES FUTCH: There is -- I don't have the numbers in my head right now as to how much of the shortfall it would cover. I can't --

REBECCA McFADDEN: Maybe an additional position that you need.

JAMES FUTCH: Yeah.

KATHLEEN DROTAR, Ph.D.: Especially for MqA to help with all the licensing.

JAMES FUTCH: Yeah. Well, it's something to take under advisement anyway. I don't know. Would the current council be opposed or in favor?

REBECCA McFADDEN: I would be in favor of an increase to provide additional resources from the State level, yeah.

KATHLEEN DROTAR, Ph.D.: As a person with three licenses, I have no objection.

REBECCA McFADDEN: She's getting paid very well with this through licenses. It's okay. Let it go up.

KATHLEEN DROTAR, Ph.D.: I wish.

RANDY SCHENKMAN, CHAIRPERSON: I think probably we all feel that if the money would be going to --

REBECCA McFADDEN: If it would go --

RANDY SCHENKMAN, CHAIRPERSON: -- to proper and good use, then we would not object.

KATHLEEN DROTAR, Ph.D.: Yeah.

REBECCA McFADDEN: Yeah. I agree, Randy.

JAMES FUTCH: We'll take that under advisement. Appreciate that.

Okay. So that was the fee increases. Let's see, what's next? I have ten minutes. Okay. We have a laser document that needs some minor tweaks. We have -- we're going to make a -- redouble our efforts try and get that --

BRENDA ANDREWS: With a new person.

JAMES FUTCH: -- with a new lawyer, the new general counsel's office. It's fairly simple when we modified this laser requirement last time, the numerical titles of the different sections, you know, laser light shows, administrative controls, engineering controls, et cetera, surveys, the kind of stuff that you expect from any radiation related, the titles were left out of the actual section. So all it has is numbers for the different sections.

So if you're reading through it, you actually have to read this massive amount of text to figure out what that section pertains to. It also doesn't have a table of contents. I have created one external to the rule process. If you go to my website, DOH website, and pull down the laser document, you'll get a document that has a table of contents. But in the actual incorporated rule on the Department of State's website, it has no table of contents nor titles for the sections. And probably by now -- have we updated the 036 again since 2018?

ADAM WEAVER: I think you're going to have to look at the classifications, too.

JAMES FUTCH: Probably. All right. So we're moving forward to try and get that.

These two areas --

ADAM WEAVER: You better hurry up because there's another draft here or one coming out soon.

JAMES FUTCH: Oh, really?

ADAM WEAVER: Yeah. Hopefully we'll know more about that next week.

JAMES FUTCH: So we're not going to talk too much about the RA section right now. The radiologist assistant, we had a whole presentation

about it last time with Christen. I've looked at the documents now and here's the short and the skinny.

We're -- our statute requires that we have a practice standard, if you will, for the RA, which is based upon the consensus agreement of ACR, ASRT and ARRT with the level of supervisions required for those procedures.

When this whole thing was coming together in 2005, those three organizations had agreement on a role delineation, which actually has one of the most specific practice standards I've ever seen by individual procedure with individual levels of personal, general or direct supervision required by the supervising radiologist.

What they have now is not that quite. What they have now, ARRT as of 2018, has an entry-level clinical activities, which actually tracts almost exactly the old document, but has no levels of supervision per procedure. It just kind of says look, if you're an entry-level RA, everything is direct. All the places if we adopted that, all the places where it says personal, those are gone, which probably maybe somewhat is desired. All of the general is gone and now it's also direct. And it's

also only for entry-level folks. So I don't really know what you do once you've been working in the profession for a while.

There is a practice standard. There are two protibations with the practice standard. It also doesn't specify levels of supervision in any kind of granular fashion. And since we last adopted practice standards for radiographers, nuclear med techs and all the different subcategories of technologies, ASRT has put them all into one document instead of separate documents for each profession.

KATHLEEN DROTAR, Ph.D.: No.

JAMES FUTCH: So reading through this -- this is just my two cents -- take it for what it is or if you care for what I think, but once you read through that document, it's footnote here, footnote here does not apply to this profession or applies to this profession because they're trying to group all the different things into like a standard area.

So if your standard is patient care, there is -- here's what the radiation therapists and nuclear med tech, what applies in this area; here's what doesn't apply, and then it gets even more specific when you get to the actual nuts and bolts

of the profession.

This is my long and short way of saying, I'm not really sure how to -- which of these documents to grab to put together to call this the replacement document. So it's going to take more thought, perhaps another shot with the committee, with an RA in place, saying is this close to what we think is what we want?

KATHLEEN DROTAR, Ph.D.: ARRT is just going to do the entry level because that's what the certification is for. However, I think I saw something that was advanced practice on the website for -- and I didn't read it, so I don't know what it is. But it was different and that might be addressing some of that. And at the House of Delegates in June, we did vote on the changing the practice standards because there was something like 800 and some pages when you put them altogether, so they were taking the common denominators, putting those together and then they will have --

JAMES FUTCH: Up in the front.

KATHLEEN DROTAR, Ph.D.: -- for each individual discipline, a separate section specific to them. So that's -- they're working on that this year, because they got it down to, I think 80 pages as opposed to

the 800.

JAMES FUTCH: To think everything being in the same document is somewhat problematic because we also just adopted the 2017 versions as separate documents in the rule. And it makes me a little queasy to have one document and to point -- because we point people to these practice standards all the time. Somebody calls up, they've got a question about this, that and the other thing, it's radiation therapy, go see this practice standard, it's incorporated here. And they can go look at it. We essentially now, we're pointing them to a document that has everything in it. From therapy, to nuclear medicine, to diagnostic imaging at the different levels of responsibility.

It's one thing to adopt a practice standard from a national association by reference in your regulation when it's at least just that profession's document that you're referring to in the regulation. When you're referring to a document, you're going to have to say, well, you know, not the whole thing. Not pages, you know, 16 and 23, 44. Just the ones that say RA. Well, it's not even all in one section because it's spread throughout the document. It's going to be a nightmare trying to do that.

There's one place in the PET standard when we allowed the nuclear medicine technologists from NOTCB with a CT certification to be granted the CT certificate up in Florida. In the PET section, which is .003, that one is written for nuclear med techs who don't have any CT certification and that one requires some additional 16 hours of training. It exempts people who have CT already, but it doesn't exempt the NOTCB CT because we forgot to do that part. So we've to do some clean up in that section.

I've got to plug this. I know it's three minutes 'til. Adam and I had this. HPS meeting next week, I finally, after literally years of trying to get this happen, we had this idea. I'm part of another group, a body that publishes the RF safety standards, that all your cell phones, FCC to protect you from RF exposure, et cetera, et cetera, et cetera.

One of my co-chairs, one of the committees, Kevin Graph, we were talking at some of the previous meetings about what really drives this issue. Because this issue is not really driven by some sort of earth-shattering science that says, oh, my goodness, all the cell phones are going to cause

cancer and we're all going to die; this kind of stuff. It's like miniscule, minor protibations in, you know, cutting-edge research that when you try and reproduce the stuff that's supposedly showed some kind of effect, you can't really reproduce it many times, so it's down in the noise.

And what happens is, people get driven by what the news media writes about what people, who they view as their professionals to take counsel from, their doctors and the other folks, industrial hygienists, health physicists, those that happen to know one. And none of those folks really have -- this is not your day-to-day, you know, thing. We're dealing with ionizing and NCRP and NCRCPD regulations and FDA and the rest of it.

So this is the talk we came up with to explain to scientific and engineering professionals, medical professionals eventually, if this works out well, to try to bring it to the Florida Medical Association and Florida Nurses Association. Who knows. But it's, how do you understand what is a good study? So this is supposed to talk about historical results, you know. What are the hallmarks in this field. What kinds of studies. What makes something good health effects research in the electromagnetic

fields. So that's what this is about.

And Kevin, who was going to give the talk, called me a week and a half ago and said he'd taken a job with FCC. So he's not going to be there unless they worked out the relationships because the FCC is really hinky to have people go out and talk about stuff like this. I mean, like no agency I've never seen before.

So his health effects, epidemiology person, Dr. Pamela Dopart, is going to be giving this particular talk at the meeting.

I should show the rest of it, shouldn't I? Emphasis is placed on the strengths and weaknesses of key historical studies and ancient research. This is the abstract. This may have changed by the time we get to the actual talk. This is what we started with and what we presented to HPS, which they accepted.

By the way, this is being offered in the morning session, because the industrial hygiene president thought it was a great idea, too.

ADAM WEAVER: Yeah, yeah. It fits them, too. They get the same questions, I would assume.

JAMES FUTCH: Yeah, it's beautiful. Then the last thing, the national safety standard was

published last Friday. HPS is about to send out an announcement to its members, which I can find some place.

ADAM WEAVER: Get it for free?

JAMES FUTCH: There it is. HPS' second point -- actually, it just released C95 -- incorporates the full spectrum. We're going all the way from essentially no fields, no, you know, zero hertz DC all the way up to 300 gig. And I actually happen to have a copy of it, which I can find, which I would very much love to show you. There it is. There's what the standard looks like.

By the way, these are available free of charge thanks to a generous donation from the U.S. military which, we built the standard for them a couple years back so they could use it, so all the NATO countries can use it when they're in different ports in Europe and around the world which may have competing standards and, hey, you can't use that radar system. Yeah, you can, it's okay. So the U.S. military has been funding the development of some of these. And this one, let's see. There you go.

I'm going to shamelessly plug this because this is the first time I ever gotten my name into one of these things.

(Laughter)

JAMES FUTCH: Finally.

(Applause)

MARK SEDDON: Good job.

JAMES FUTCH: I'm done.

ADAM WEAVER: Good way to leave it.

(Laughter)

JAMES FUTCH: I remember when Debbie Gilley did this with NCRP 161.

RANDY SCHENKMAN, CHAIRPERSON: Okay. So old business. Anybody have anything for old business?

(No Response)

RANDY SCHENKMAN, CHAIRPERSON: No?

KATHLEEN DROTAR, Ph.D.: No.

RANDY SCHENKMAN, CHAIRPERSON: Okay. Onward ho. Administrative update. Brenda.

BRENDA ANDREWS: Okay. In your packets, I included a copy of the updated roster for the council members. And we talked, last time we met, about those who are coming up for term end, ending, October 27th. And right now, we have submitted letters --

(Member sneezing)

BRENDA ANDREWS: Bless you. Are you allergic to me talking?

(Member sneezing)

(Laughter)

BRENDA ANDREWS: All right. Right now, we have the podiatric, the certified podiatric position that's vacant right now that Stratios was the member for that position. And we have a nominee for that position whose name we have put forth. Some of the council members may know him from when he served on the council before. He ended his term in 2012, I believe it was. His name was Albert Armstrong. He has shown a desire to come back to the committee and was nominated for that by the society. So his name has been put forth in our appointment package that we've submitted.

We also have two other names of current council members who wish to renew. And we have gotten the society letters back on them and we put their names forth as well. And that would be Mark, I've got your name in the pot. And Mark, the other Mark, Mark Wroblewski is in the pot.

We will have a second round, which would include certified health physicists, an expert in environmental matters and then Christen Crane-Amores' position, the certified radiologist assistant, as James mentioned earlier, with her new endeavors and

her new family situation, she's got a lot on her plate. So she has opted not to seek reappointment after October 27. So we are looking forward to getting a nominee for that position as well. We've gotten some applications on it, but not a letter from a society yet.

So once we get all that and get it vetted, we will be sending through the second group, second and final group for the last three people. So until then, as we get those nominations, we will notify you and let you know if your name came up as the chosen person for reappointment.

And let's see. Anything else you wanted to say about the appointments? That's it. So that's where we are with that. Any questions on what's happening with our vacancies?

(No Response)

BRENDA ANDREWS: I guess the next thing is to decide on when we're going to meet again. In your packet, I have two calendars, April and May. So you want to talk about that?

RANDY SCHENKMAN, CHAIRPERSON: May would be better for me. I don't know about anybody else.

BRENDA ANDREWS: Okay. Everybody good in May? Okay.

KATHLEEN DROTAR, Ph.D.: Just not the first week.

BRENDA ANDREWS: Not the first week. Okay. Okay. So we've got the 12th, 19th and the 26th.

CLARK ELDREDGE: CRCPD, when is that?

CYNTHIA BECKER: May 4th through the 7th.

BRENDA ANDREWS: Okay. That's that same week. Anybody want the second week? Is that --

CYNTHIA BECKER: May 12.

BRENDA ANDREWS: May 12. Anything going on that week for anybody?

REBECCA McFADDEN: I'm trying to figure out what's going on tomorrow.

KATHLEEN DROTAR, Ph.D.: Sounds okay.

BRENDA ANDREWS: What's that?

REBECCA McFADDEN: I'm trying to figure out what's going on tomorrow.

(Laughter)

BRENDA ANDREWS: Well, we have time.

MARK SEDDON: The 12th is good.

REBECCA McFADDEN: 12th works.

BRENDA ANDREWS: Okay. Let me say this: The other thing is, we like to make sure we get our bid in for the meeting space because when I did it before, I was pretty sure we were way ahead of time

to get the Hampton Inn again with their nice windows, and it was already booked.

ADAM WEAVER: Really?

BRENDA ANDREWS: Yeah. So it turned out fine. We got another nice room, but people are booking these rooms up really fast. So the better -- the sooner we get it in, the better.

Now, if there's going to be a problem with us getting either one of the rooms down here at this complex, I'll let everybody know so we can perhaps choose another date and I'll get them to give me some other dates. Whether the 19th or the 26th might be available, if that's the date.

CLARK ELDREDGE: The 26th would be --

BRENDA ANDREWS: That's Memorial Day.

CLARK ELDREDGE: Yeah. The 25th would be.

BRENDA ANDREWS: So the 25th is a holiday.

NICHOLAS PLAXTON: Probably use the 19th as a back up.

BRENDA ANDREWS: What's that?

NICHOLAS PLAXTON: Use the 19th as a back up if you can't get the 12th.

BRENDA ANDREWS: Okay. All right. I'll check on that pretty much when I leave here because I don't want us to lose a place down here. This is a

really nice complex.

NICHOLAS PLAXTON: It is.

BRENDA ANDREWS: Very convenient for everybody. Okay. That's me.

RANDY SCHENKMAN, CHAIRPERSON: Okay. Well, anybody have anything else that they want to talk about or comment on?

(No Response)

RANDY SCHENKMAN, CHAIRPERSON: And then I guess we are adjourned.

REBECCA McFADDEN: Thank you.

(Proceedings concluded at 3:12 p.m.)

CERTIFICATE OF REPORTER

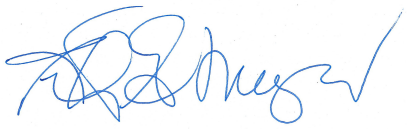
STATE OF FLORIDA:

COUNTY OF HILLSBOROUGH:

I, RITA G. MEYER, RDR, CRR, CRC, do hereby certify that I was authorized to and did stenographically report the foregoing proceedings and that the foregoing transcript is a true and correct record of my stenographic notes.

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 connected with the action, nor am I financially interested in the outcome of the action.

DATED this 23rd day of October, 2019.



RITA G. MEYER, RDR, CRR, CRC