ADVISORY COUNCIL ON RADIATION PROTECTION

BUREAU OF RADIATION CONTROL

Tampa, Florida 10/08/2019

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9 TRANSCRIPT
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14 Tampa, Florida 33607
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Reported by
24 Rita G. Meyer, RDR, CRR, CRC
Realtime Reporter and Notary Public
25 State of Florida at Large

1 ADVISORY COUNCIL MEMBERS PRESENT:

2 Randy Schenkman, M.D., Retired (Chairman)
Mark S. Seddon, M.P., DABR, DABMP (Vice-Chairman)
3 Kathleen Drotar, Ph.D., M.Ed., RT. (R)(N)(T)
Albert Tineo, MS, CNMT
4 Rebecca McFadden, RT(R)
Matthew Walser, PA-C, ATC
5 Nicholas Plaxton, M.D.
Adam Weaver, MS, CHP
6

7 FLORIDA DEPARTMENT OF HEALTH STAFF

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

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1 RANDY SCHENKMAN, CHAIRPERSON: So this is our
2 October 8th, 2019 meeting. And I thought even
3 though we don't really have anybody new, it wouldn't
4 hurt for everybody to go around and reintroduce
5 themselves so everybody knows who's who, so I'll
6 start.
7 I'm Dr. Randy Schenkman. I am a retired
8 radiologist. My specialty is women's imaging and
9 breast imaging in Miami at Baptist Health System.
10 MARK SEDDON: I am Mark Seddon. I'm a
11 diagnostic medical physicist. And I'm the RSO and
12 chief physicist for the Advent Hospital systems in
13 the north and southeast regions of Florida.
14 KEVIN KUNDER: I'm Kevin Kunder. I'm with the
15 Bureau of Radiation Control. I'm the radioactive
16 materials administrator.
17 KATHLEEN DROTAR, Ph.D.: I'm Dr. Kathy Drotar.
18 I'm the radiation therapy board member and program
19 director for radiology at Keiser University and also
20 vice-president of the Florida Society of Radiologic
21 Technologists.
22 ADAM WEAVER: I'm Adam Weaver, University of
23 South Florida in Tampa. I'm a radiation safety and
24 laser safety officer.
25 NICHOLAS PLAXTON, M.D.: I'm Nicholas Plaxton.

1 I'm a nuclear medicine physician over at Bay Pines.
2 MATTHEW WALSER: I'm Matt Walser. I'm a
3 physician assistant up in Gainesville at UF Health
4 and I don't do anything with radiation.
5 REBECCA McFADDEN: I'm Becky McFadden. I'm
6 from Advent Health Ocala. I'm the non-invasive
7 radiology manager currently but I am sitting on the
8 counsel as the radiologist technologist position and
9 I still interact with a lot of the schools in
10 radiology even though my specialty is cardiology
11 these days, which has recently changed.
12 ALBERTO TINEO: I'm Alberto Tineo from Halifax
13 Health in Daytona Beach.
14 CLARK ELDREDGE: Clark Eldredge, Florida
15 Department of Health, Bureau of Radiation Control,
16 radiation machine administrator.
17 BRENDA ANDREWS: Brenda Andrews with Bureau of
18 Radiation Control.
19 CYNTHIA BECKER: Hi. Cindy Becker, Bureau of
20 Radiation Control.
21 JAMES FUTCH: And James Futch, administrator of
22 the technology section, Bureau of Radiation Control.
23 RANDY SCHENKMAN, CHAIRPERSON: Okay. So
24 welcome.
25 We have to approve our minutes from May 23rd of

1 2019. Does anyone have any questions, comments?
2 BRENDA ANDREWS: We did make a few changes.
3 Kathy Drotar sent a couple things in for us to
4 change, which they were made, and there were a few
5 name changes or corrections and some terminology
6 corrections, acronym corrections and all of those
7 were made.
8 RANDY SCHENKMAN, CHAIRPERSON: Okay. So were
9 there any other comments? Was that all?
10 KATHLEEN DROTAR, Ph.D.: That was all, yes, it
11 was. Thank you.
12 RANDY SCHENKMAN, CHAIRPERSON: Okay. So we'll
13 make a motion. All in favor of approval, say aye.
14 COUNCIL MEMBERS: Aye.
15 RANDY SCHENKMAN, CHAIRPERSON: Any opposed?
16 (No Response)
17 RANDY SCHENKMAN, CHAIRPERSON: So passes
18 unanimously. Okay.
19 Now Cindy, it's your bureau updates.
20 CYNTHIA BECKER: Okay. I talked with a few of
21 as you came in today, but I was going to talk a
22 little bit about our staff -- our current staff and
23 our new staff.
24 Our vacancies, we have seven new staff within
25 the last six months. So we've been on a roll right

1 now to fill positions. We do have a full field
2 inspection staff now.
3 Johnny Frazier is with the radiation machine
4 section. He was newly hired. So he's helping out
5 with the 18,000, maybe 19,000 plus registrations
6 that are coming in this time of year. They have a
7 full staff now. Yay. We even have a contract
8 person helping out through December.
9 Terry Hague. I didn't know if you were going
10 to mention him, but he's our new IT person that was
11 hired working with James and Brad and Nina. So
12 that's been very helpful.
13 Kevin, we've got you on the list, but you did
14 start in April, so he came to the last meeting in
15 May.
16 Chris Wallace, he is an inspector that is in
17 the Tampa area. Chris -- Miami area. So whoever's
18 in Miami may see him.
19 Andson Harrison. Andson is in Tampa. He's a
20 newly hired inspector and as well as Carmen
21 Hernandez in Tampa.
22 And then Hilda Anaya, she's a staff assistant
23 that is actually working for the central office, but
24 she is located at our lab in Orlando. So that's our
25 newest staff in the last six months.

1 We still have five vacancies, three of which
2 are in the lab section for John Williamson. So wish
3 him luck in filling those. We have one in the
4 materials section and we have one that we're trying
5 to figure out what to do with, I guess at the
6 moment, but it's been vacant for a little while. So
7 that's kind of our five vacancies for our staff.
8 We have travel restrictions going on through
9 October 27th. So we're here because this is
10 statutorily required that we meet at least twice a
11 year. So you're lucky enough to be here.
12 The Health Physics Society Florida Chapter
13 meeting will be a little bit slim this year with our
14 attendance. Usually we have five to ten people
15 attending that and this year, it might only be James
16 attending. So you have to represent us well.
17 JAMES FUTCH: Save all your questions and I'll
18 answer all of them.
19 CYNTHIA BECKER: Represent us well.
20 JAMES FUTCH: I might still have a job.
21 CYNTHIA BECKER: So in the last six months
22 since we met, we had our integrated materials
23 evaluation program evaluation, how it's IMPEP'D. We
24 were IMPEP'D. The evaluation audit that's done
25 every four years by the NRC. They have oversight of

1 our program, just like we have oversight of
2 licensing programs that -- around the state. They
3 have oversight of ours.
4 So they spent a couple weeks with 14 of our
5 inspectors out in the field. That was in April and
6 May. And then in June, the last week of June, they
7 spent a week up in Tallahassee going over our
8 licensing files, interviewing staff, looking at our
9 training records. Adam knows the drill from being
10 in Tampa before. He probably got accompanied
11 before.
12 So it was a very extremely thorough audit. I
13 don't recall ever having one like that before. It
14 was a very good team that they had put together.
15 And a few things they uncovered for us, which really
16 actually helped us.
17 As you know, we had a turnover of some critical
18 staff within the last couple years. And I think
19 really because of that and because of all the other
20 things happening, we didn't really keep up with Part
21 37 changes as we should have. So they noticed that
22 we did have some knowledge gaps in that area. And
23 we implemented some new procedures. We did some
24 extensive training. Thanks to our fellow help here
25 from Mark Seddon and folks at his facility, we did a

1 lot of training after they left.
2 And with that, I think we're now more up to
3 speed with where we need to be. It doesn't stop, of
4 course. We're continuing the training. We took a
5 lot of our staff out to some facilities and -- both
6 in Tallahassee and down in Orlando and we were lucky
7 enough to observe, ask a lot of questions, get some
8 demonstrations about what physical security measures
9 should be in place for some of our high-risk
10 licensees like gamma knife and dust radiography;
11 that sort of thing, so I think we're on our way now
12 to kind of enhance some of our training and our
13 procedures that needed to be enhanced.
14 That was one of the things that they picked up
15 on. The other thing was compatibility requirements
16 and that has to do with we have to maintain
17 compatibility with the Nuclear Regulatory
18 Commission. When they implement rules, we have to
19 be consistent with the adoption of our rules and
20 have to be timely within three years. And we were
21 behind on some of that as well.
22 So Kevin and I went up to DC and expressed how
23 we had started really implementing some of these
24 changes and I think it went well. And I think he's
25 going to talk a little bit about where we are with

1 the trying to adopt some of those rules. At least
2 we got language put together. But he's going to
3 talk a little bit about the compatibility part. So
4 we're kind of tag teaming.
5 That's kind of all the updates I have. Unless
6 you guys have any questions for me about staffing or
7 what's going on in our bureau, that's what we're
8 here to talk about. But that kind of took over our
9 world for the last six months.
10 RANDY SCHENKMAN, CHAIRPERSON: Do you have
11 candidates that you're thinking about for the
12 staffing?
13 CYNTHIA BECKER: For the staffing, Reno -- poor
14 Reno. Reno has picked out several different really
15 highly qualified staff and he would get them right
16 to the point of accepting the job, and then they
17 would say, never mind. I've gotten another job.
18 Usually for more money. I know, it's sad. So that,
19 that was about three times he's had that happen.
20 But he does have some staff in mind for his
21 position.
22 BRENDA ANDREWS: John does, too --
23 CYNTHIA BECKER: Yes, John does, too.
24 BRENDA ANDREWS: -- for the manager. We have
25 one that's moving through the system pretty well

1 right now. A lady from Texas for one of his manager
2 positions.
3 CYNTHIA BECKER: Yes, she looks highly
4 qualified.
5 BRENDA ANDREWS: She's very highly qualified.
6 CYNTHIA BECKER: That would be good. As you
7 know, it takes the State some time to get through
8 the system, hiring system and I hate that part
9 because you're waiting for somebody to start, you're
10 waiting for somebody to start, and so --
11 BRENDA ANDREWS: Mm-hmm.
12 CYNTHIA BECKER: Hopefully that will go
13 through.
14 MARK SEDDON: Are there any critical openings
15 that are potentially affecting your guy's ability to
16 maintain, keep up with IMPEP?
17 CYNTHIA BECKER: No, because all the inspection
18 field staff are now filled and they've actually been
19 trained and are out there starting to do
20 inspections. So that is good. Also, the materials
21 staff is well on their way. They only have the one
22 vacancy now that's going to be the end of October
23 when Joe retires. So I think we're, we're good in
24 that area. Yeah. So I guess I'm passing it to
25 Kevin now.

1 KEVIN KUNDER: Just an overview of the rule
2 changes. Why we fell behind was I guess because of
3 Governor Rick Scott, when he came in, on his first
4 day, he signed Executive Order 11-01 and it was
5 titled Suspending Rulemaking and Establishing the
6 Office of Fiscal Accountability and Regulations
7 Reform or OFARR. So we kind of fell behind with
8 doing some of the rule developments that came down.
9 As Cindy mentioned, we jumped on things right
10 away when we found out that we were behind, and the
11 end of June, we submitted some things and gotten
12 those things back already from the NRC. We got
13 everything else in by the time that Cindy and I went
14 up to DC, so that would've been the second week of
15 in September. So we had everything in for the first
16 run of the stuff to the NRC.
17 Some examples, some of the changes for medical
18 training and education, which is removing the
19 competency statement and adding if they're Board
20 certified, they do not need attestation. So we're
21 working on that. Yet another medical was adding and
22 defining something we haven't had before, but
23 they're calling it Associate RSO. We have an
24 Associate RSO on the license as well.
25 Nuclear pharmacy. They're expanding some of the

1 compatibilities with that. We're looking at our
2 existing licenses with the nuclear pharmacies, there
3 was no, no effect on the existing licensees.
4 Source material exemptions. For general license
5 source materials written, regs are being written to
6 be more compatible and adding requirements to be
7 able to distribute.
8 Industrial radiography. There was just some
9 definition changes for temporary location and
10 mailing address changes we had to make and then
11 source and device registry, basically just some
12 updates for compatibility with the NRC guidance
13 documents. And I think the only difference
14 between what they have and what we're going to have
15 is, ours is going to be specific to Florida.
16 So that's some of the stuff that we're working
17 on. We're just waiting to get that stuff back
18 from the NRC and continue with that.
19 For Materials, we had two medical events since
20 the last time we were here. One was an HDR using a
21 SAVI system. Treatment was a week long, two times a
22 day, for days. And on the third, third or fourth
23 treatment, they went ahead and the physicist had
24 started the procedure and when it was sending in the
25 source to check the resistance of the channels, it

1 popped up and said it had some resistance and said,
2 do you want to abort or continue? And the physicist
3 just hit the abort. So it took it out altogether, --
4 it took the treatment plan out of the system
5 altogether. And then he brought back in the next
6 patient, which was the top on the list. The patient
7 was familiar with him because he's already dosed
8 that patient. And it ended up being, the SAVI was
9 for the breast. The next patient was a vaginal. So
10 they went and started that and he was in the room
11 waiting for it to transfer and decided it wasn't
12 transferring and stopped it right there.
13 So the patient was supposed to get 3400 cGy for
14 the whole treatment and the individual ones were
15 supposed to be 340 cGy and they received 680. So
16 they ended up just doing one less fraction for that.
17 The second medical event was TheraSphere. And
18 it was a patient having to follow-up treatment a
19 year later. Right lobe of liver had been treated
20 the year prior and this time, it was a kind of in
21 between segment of the right lobe. So they went in
22 and they had prescribed 0.3 GBq dose, which meant,
23 if you guys, I don't know if you're familiar with
24 nuclear medicine, we draw up a dose, we order a
25 dose in for what we're going to use at that time.

1 For this TheraSphere, they order from the
2 manufacturer a higher dose, and they look at for it
3 to be decayed down by the time you use it to the
4 dose they want to use.
5 So they ended up giving and grabbing another
6 dose for a patient later in the week that was a
7 higher dose instead of 3 GBq ordered dose, it was
8 a 5 GBq ordered dose. So the patient ended up,
9 instead of getting 120 Gy, they got 678 Gy. So
10 those were the two medical events.
11 And then I think, as Cindy mentioned, as far as
12 my staffing goes in Materials, when Joy Stevenson
13 took my consultant position, it left an evaluator
14 position open. Lynn Andresen, who's been in the
15 technology section, she moved over on Friday to my
16 section. And she's going to start doing -- being
17 another evaluator of mine. She's in training right
18 now, so it fills that position that was open last
19 time.
20 And as Cindy was mentioning, I'm going to be
21 losing Joe. Joe Major is going to be retiring.
22 He does the inspection reviews for license --
23 for the materials section. And he'll leave the end of
24 this month. So I have that position open.·
25 It's still open for another week out there if anybody

1 knows anybody. But that's all for my openings and
2 Medical events. Does anybody have any questions?
3 REBECCA McFADDEN:· Is your opening in
4 Tallahassee?
5 KEVIN KUNDER:· Yes, it is.
6 MARK SEDDON:· For the TheraSpheres, have you
7 guys done the investigation yet?
8 KEVIN KUNDER:· Yes. Yes.
9 MARK SEDDON:· Have you made recommendations to
10 them?
11 KEVIN KUNDER:· Yes.
12 MARK SEDDON:· Do you want to follow-up?· There
13 should be a time out treatment. Time out for the
14 treatment with the interventional group to verify
15 the dose?
16 KEVIN KUNDER:· They are a Joint Commission site.
17 They should have been doing that.
18 MARK SEDDON:· Yeah, because what happens, they do
19 a time out for Joint Commission, they do that for the
20 patient, and for the interventional part, but they
21 also must verify the assayed dose and prescribed dose.
22 KEVIN KUNDER:· When the new person comes in the
23 room and they bring new doses, they go through that
24 again.
25 MARK SEDDON:· Right. We're doing that too.

1 NICHOLAS PLAXTON, M.D.: When that dose showed
2 up in the department, I mean, they should be
3 measuring what the dose is. They should have
4 known because it's a week difference you're
5 saying?
6 KEVIN KUNDER: It was three days I don't know
7 how much detail to go into because it's still
8 active. We're still working through.
9 CYNTHIA BECKER: It's fine.
10 KEVIN KUNDER: But the RSO nuclear medicine
11 technologist, in his mind, because again, it's a
12 difference between, you know, I call the nuclear
13 pharmacy, I order 20 mCi bone dose and I look
14 and I throw it in the dose caliber, it's 20 mCi,
15 I'm good to go. On this one here, they needed
16 a .3 GBq. I had to order that dose for Tuesday.
17 So the prior Sunday -- not that Sunday, but the
18 prior Sunday before, I had to order a 0.3 GBq
19 dose so it decays down to that. So what he was
20 doing is he was looking at the dose calibrator.
21 NICHOLAS PLAXTON, M.D.:· Sure.
22 KEVIN KUNDER:· -- The dose that was in the dose
23 · calibrator, which is now three.· He's looking at the
24 · order instead of the prescribed dose.· So he did
25 · measure that morning when they said, okay, I've

1 got a patient here. Can we start? Do we have a
2 dose? He measured it. And then just prior to them
3 bringing it over to the interventional lab,
4 measured it again. But that's in his mind, he was
5 looking at that.
6 NICHOLAS PLAXTON, M.D.: I see. Got it.
7 MARK SEDDON: The other trick with TheraSphere
8 is a lot of time they hand write everything out in
9 the nuclear medicine lab without doing the
10 calculation in a spreadsheet.
11 So you also want them to make sure they enter
12 the date in a spreadsheet so it calculates out and
13 flags them beforehand so that when the authorized
14 user signs off on that spreadsheet before they dose
15 a patient, that would've been caught with the
16 doctor.
17 NICHOLAS PLAXTON, M.D.: That's what we do. We
18 do the spreadsheet. It is a lot of hand calculations.
19 MARK SEDDON: Yeah, it's a lot of hand
20 calculations but then you --
21 NICHOLAS PLAXTON, M.D.: You want a spreadsheet
22 to catch it.
23 MARK SEDDON: Because they're not using --
24 nuclear medicine techs aren't using GBq units.
25 It's kind of foreign to them a little bit.

1 These are just some recommendations.
2 KEVIN KUNDER: All right. Thank you.
3 RANDY SCHENKMAN, CHAIRPERSON: Okay. Now we
4 turn it over to James.
5 JAMES FUTCH: All right. So in this little
6 section, we would normally have Gail Curry or one of
7 her staff. They've had some staff out for quite a
8 bit and are doing some catch up. So they forwarded
9 some things to me to provide to you for this today
10 for MQA.
11 So as they often do, we start out with numbers.
12 And MQA, of course, at the program office is focused
13 on the licensing of technologists. So they usually
14 give us a current total. So right now there are
15 numbers as you see them on the screen. 22,500 plus
16 radiographers, 2500 plus nuclear med techs,
17 radiation therapists, a little under 2,000 and
18 radiologist assistants, current clear and active,
19 32.
20 I think looking at the license numbers, at one
21 point, the license numbers were up to like 114. So
22 the balance of the radiologist assistants have, I
23 guess, expired and not been renewed. There's about
24 32 active at the moment.
25 They didn't give all the different kinds of

1 techs. The computer tomographers, 545 clear and
2 active. There's also a fair number of
3 mammographers that didn't make it into the list
4 and basic machine operators, just over 2,000.
5 And the total is 28,383 clear and active
6 licenses. And that number varies whether or not
7 you're talking about licenses or actual people
8 because people can hold multiple licenses.
9 If they have a completed application, which
10 to them means that it's come in, it's got all
11 of its paperwork, it's got all of its money,
12 there's nothing wrong in the system preventing
13 that particular application being processed,
14 they get it done, in less than, a day is their
15 average statistics. Of course, the long period of
16 time is getting all of the documents needed to
17 make the application complete and bring it all
18 together so the staff can act on it. But this
19 is a reflection of how fast they get to it if it
20 actually comes in that way from the very
21 beginning.
22 And they're up to date on their backlog. It
23 looks like they only have six applications as of
24 today that aren't being worked, which is
25 tremendous,because at one point there were

1 many, many folks backlogged and they've done
2 a really good job of catching up with all of
3 that. So that's the MqA update.
4 ALBERT TINEO: Any reason why the radiology
5 assistants are not renewed?
6 JAMES FUTCH: I'm not really sure.
7 ALBERT TINEO: Is it jobs or is it --
8 JAMES FUTCH: We had a discussion last meeting
9 from Christen Crane-Amores, who is the radiologist
10 assistant on the council. And she -- I think she
11 had spoke to, I forget exactly what she had brought
12 up about that. But it's always been, this
13 profession was created around 2008 in Florida, if I
14 remember right. And it's never, it's never been
15 more than 100, I think, licensees. And I think
16 maybe --
17 KATHLEEN DROTAR, Ph.D.: I can add to that.
18 One of the reasons is because CMS, in its infinite
19 wisdom, had blocked or had stated that a
20 radiologist had to be present in the room. And
21 so there are a couple bills in Congress to try
22 and get that unbundled so that the radiologic
23 assistants can then function as they've been
24 trained to do.· And so I can get those bill
25 numbers for you to and send that.

1 But what happens is, when Sarasota Memorial,
2 which is like one of the third largest in the state,
3 and they don't hire RAs because the radiologist has
4 to be there. And they can do more with a PA not in
5 the radiology department, but because they can see
6 more patients. It's not cost effective for them to
7 do that. And then you also need to have a
8 radiologist who is willing to have that person
9 working with them, too. I don't think that that's
10 so much an issue.
11 But that the positions aren't there because of
12 the way their reimbursement falls out. They have
13 not been able to do the job that they've been
14 trained to do and are certified to do. But Florida
15 also has the largest number of radiologist
16 assistants in the states, so -- yeah.
17 JAMES FUTCH: Okay. We -- there was a bit of
18 discussion about that after Chris's talk last time,
19 so I went out and looked at our current practice
20 standard, which is role delineation, and the current
21 one that ASRT has out there and also the ARRT
22 entry-level clinical activities document and I've
23 done a little bit of an update about that in the
24 technology section, which is scheduled for, I think
25 2 o'clock this afternoon. So we'll come back to

1 that.
2 ALBERT TINEO: Okay.
3 JAMES FUTCH: There were, while I'm on the
4 subject of MQA updates, there were two other issues
5 that came up at the last meeting which MQA was
6 involved with.
7 Chantel had brought up an issue that some of
8 her members who, NMTCB has the relatively new
9 certification. And we had changed our regulation
10 last year to allow a person with that credential to
11 apply for the Florida CT license by endorsement.
12 We've had the ARRT pathway for a number of years
13 now. And she reported that there was some
14 difficulty with her association members saying they
15 couldn't apply online and asked us to look into it.
16 So MQA went back and talked to their IT folks.
17 I went back and talked to our IT folks and have a
18 little bit of an update to show about that one
19 issue.
20 So the CT online application, you can
21 actually -- I can find some screen shots here. So
22 this is what the online application screen looks
23 like and -- on the department's website. And this
24 entry number here, this entry right here, it's entry
25 number five on the menu, that presents a person who

1 applies for any kind of license with the radiologic
2 technology. And this is for certified rad techs by
3 endorsement.
4 So you can actually use this menu item. When
5 you do, it drops you into this screen and shows you
6 essentially the equivalent of all the instruction
7 information that would appear on a paper form.
8 Talks about what you have to have and the rest of
9 it.
10 So if you have no CT license at all, if you
11 have no license at all, you would come here to apply
12 by endorsement. So this is the pathway that
13 Chantel's members should have been using, would've
14 been using. We haven't gotten detailed information
15 back from Chantel about which particular people. I
16 don't think they gave her enough detailed
17 information to be useful for diagnosis purposes on
18 our end. So we just kind of jumped in and started
19 fiddling around, trying to figure out what we could
20 find.
21 So the first screen is an instructional screen.
22 If you press next here on the bottom right, it takes
23 you to the following. And it starts to ask you some
24 of the basic initial questions with the way this
25 system is designed. Are you 18? These are things

1 that are in the statute or the application process.
2 Are you 18? Are you registered -- this is the key
3 one in this case. Are you registered with ARRT or
4 NMTCB? Yes, no. Have you completed a two-year
5 program? And depending upon these answers, you get
6 to various screens.
7 And the one that's relevant to this, this is
8 a -- I am sorry. This is another -- if you happen
9 to have a -- be a military veteran, there's certain
10 kinds of experience you are exempted from certain
11 requirements, so you would fill out this screen,
12 which is irrelevant to the issue that Chantel's
13 folks were talking about.
14 Then you come to the basic informational screen
15 which is to fill out, you know, the basic
16 information about yourself. What is your birthday,
17 what is your Social Security number and so forth and
18 so on.
19 So here's where different things happen and
20 here's where it's not -- it's not really an error.
21 It's the system trying to protect the licensing
22 integrity. If you put in a Social Security number
23 here and you've never been licensed before, it will
24 allow you to proceed and fill out, yes, I have a CT
25 license. If you're currently licensed in another

1 rad tech area, like if you're a general radiographer
2 or in Chantel's case, if you're a nuclear medicine
3 technologist, when you put your Social Security
4 number in the screen, the system is going to look
5 for existing licenses. And it's going to find them,
6 because you're, you know, a nuclear med tech or
7 you're licensed as such in Florida. And it's going
8 to throw this error up here. It appears from our
9 records you've already got a record -- actually a
10 license in our system; therefore you cannot apply
11 for additional licensure through this mechanism.
12 At this point what you have to do, if you're
13 the nuclear med tech and you wanted to add the CT,
14 you have to bounce back to the PDF application,
15 which is on the same site and fill that out and
16 submit, not apply through this interactive online
17 system, which allows uploading of documents and so
18 forth and so on.
19 So in a way, it was designed this way. What's
20 happened, though, is there's no alternative pathway.
21 We had such a pathway when we first put the system
22 up. I don't know if you remember when they put the
23 system up in, gosh, I don't know, 2010 or something
24 like that. There were literally 20, I think, or so,
25 different -- this is option number five. There were

1 20 or so different options on the front screen. And
2 the system was not designed to be able to, for
3 example, I want to be a GR. Well, you want to be GR
4 by exam or you want to be GR by endorsement? Do you
5 have a veteran with GR by exam or veteran by
6 endorsement? So every single kind of license you
7 could think of, there were about five different
8 individual ways that you could pick from the menu to
9 be licensed by. It was just absolutely
10 overwhelming. So we started combining some things.
11 So this particular option five here is the
12 option for endorsement pathway for all of the
13 different kinds of licensed technologists except for
14 basics.
15 In that process, we eliminated the ability to
16 add a license because we were simplifying down. So
17 now we have a ticket open with the IT department to
18 basically add that back to this online system. This
19 will cost a little bit of money. Undetermined.
20 Hopefully doesn't involve any programming by the
21 subcontractor because then it's a lot of money.
22 Something like, I think they bill at like $1400 a
23 hour or $1400 a day per hour or something like that.
24 It needs assistant time. But we haven't gotten the
25 response back from the initial ticket. I think it's

1 quite likely no additional outside programming would
2 be necessary, in which case it's just the in-house
3 staff and there would be minimal cost to it.
4 The other issue is getting through all of the
5 issues and problems and requests coming in from all
6 the other professions to the IT department. You
7 know, if you guys have ever gone to your facility
8 and opened a help desk ticket and say, oh, it will
9 happen this afternoon, right? Kevin knows this is
10 only true for us. Kevin's help desk person is like
11 three doors away from him.
12 So this is something that will be fixed. We'll
13 add this and maybe by the next meeting, we'll have
14 some -- hopefully it will be finished, but at least
15 we'll have some progress to report on this
16 particular issue.
17 The bottom line is if someone does have an
18 existing license and they want to add something
19 else, you're going to use the online PDF form and
20 e-mail it in to us instead of being able to use this
21 interactive system.
22 KATHLEEN DROTAR, Ph.D.: That was the question
23 I had because we have students applying for their
24 temp license, and they have a -- they may have a BMO
25 license.

1 JAMES FUTCH: It prevents them?
2 KATHLEEN DROTAR, Ph.D.: It prevents them.
3 They have to fill out the form and send it in. But
4 it can be e-mailed?
5 JAMES FUTCH: Yeah. To the department, yeah.
6 KATHLEEN DROTAR, Ph.D.: Okay. Thank you.
7 JAMES FUTCH: We had -- we were going through
8 this diagnosis problems with the head of the IT
9 section. His name is Stephen. And he got to this
10 and he said, well, it's really only a problem if
11 they put in, you know, their actual Social Security
12 number. Of course, if they don't, then we have
13 other problems. If you put in a fake Social
14 Security number, the license is issued in the fake
15 Social Security number and then change it. I'm
16 kidding, of course.
17 MATTHEW WALSER: James, can you go back a
18 couple screens?
19 JAMES FUTCH: Sure.
20 MATTHEW WALSER: There was a question that says
21 are you a --
22 KATHLEEN DROTAR, Ph.D.: Computer tomography.
23 MATTHEW WALSER: Yeah, I was like, am I reading
24 that wrong?
25 JAMES FUTCH: No. She had to pick the license

1 type she wanted. No, you aren't reading it wrong.
2 MATTHEW WALSER: Right there. Yeah.
3 KATHLEEN DROTAR, Ph.D.: Under military.
4 MATTHEW WALSER: Are you a --
5 JAMES FUTCH: Look at the previous screen.
6 It's not showing. There's a screen where you have
7 to pick the license type and she picked from the
8 drop down, CT, and it came back with this question.
9 So when we set the system up originally, all of
10 the professions were listed as the name of the
11 professional. So you were a general radiographer.
12 You were a nuclear medicine technologist. And then
13 years later when we had the authorization to do the
14 specialty technologists, like the computer
15 tomographers, it just grabbed the type of license
16 that we had used in the regulation, which was, are
17 you certified in computer tomography? Do you have a
18 license or do you want a license in computer
19 tomography?
20 So we need to go through here and use the same
21 thinking from top to bottom. But I've got to tell
22 you, this looks so simple from this end. But you
23 get into this thing --
24 MATTHEW WALSER: Just put another ticket in.
25 JAMES FUTCH: Yeah. Two years from now, they

1 will fix that. I'm sorry, did I say that?
2 There is a certain amount of unhappiness in
3 not, not in the Bureau of Radiation Control's world,
4 but in the MqA side with the Department of Health
5 with this online system. Unhappiness to the degree
6 that they really don't want to continue with it. I
7 don't know if they have enough money or time or
8 management willpower to go to something else. I'm
9 hoping I'm retired by the time they do.
10 (Laughter)
11 NICHOLAS PLAXTON, M.D.: What would be the
12 other option? Like hand forms or something?
13 MATTHEW WALSER: We used to be hand forms,
14 right? I know in the PA side, it was and it was
15 very, very slow and painful.
16 JAMES FUTCH: We never lost the ability to use
17 a piece of paper or a PDF. A slightly modified
18 version of a piece of paper.
19 MATTHEW WALSER: Okay.
20 JAMES FUTCH: There was a previous online
21 system. I don't remember that much about it.
22 KATHLEEN DROTAR, Ph.D.: It was even bulkier
23 than this one.
24 JAMES FUTCH: There were other -- this is all
25 provided by subcontractors. Originally, the

1 contractor was a Canadian subcontractor back when we
2 first moved into the system in 2005 and we worked
3 for literally a year on this one profession,
4 building all the rules and helping them to
5 understand how it works to get that old system to
6 work. And this current one is another subsequent
7 contractor. I assume -- I think they've actually
8 said this -- I can't remember the names. There are
9 other folks out there who can provide online
10 licensing.
11 The Department of Business and Professional
12 Regulation, apparently we use -- we used to use the
13 same system. And I'm not sure if this particular
14 piece is what they're using or not. DPR for the
15 veterinarians and real estate agents or whatever
16 else they handle. They seem to like theirs.
17 KATHLEEN DROTAR, Ph.D.: As the end user, with
18 students, because we use the system about every four
19 months, and it's different every time. We go in
20 which, it's okay, we can deal with that part. But
21 the -- it's not -- it's more user friendly than some
22 of the previous versions, but it's still, with the
23 student that have or graduates at this point that
24 have the temporary license, when they get their ARRT
25 information, they're supposed to send it in. Well,

1 they can fax it in. But there's -- and I think the
2 letter they get tells them they can upload it, but
3 there is no site or there is no way on -- when you
4 have the temporary license account, to go in and add
5 in documents. At least we couldn't find one. It
6 might go back to this same kind of thing they're
7 trying to fix here.
8 JAMES FUTCH: Yeah. I will try have an MqA
9 representative here next time because everything you
10 speak is something that we've heard and reported.
11 And we belong to the Bureau of Radiation Control.
12 We work for the Department of Health. MqA is a
13 entirely different section and there are lots of
14 folks. There's lots of professions.
15 KATHLEEN DROTAR, Ph.D.: There's lots, yes.
16 And the staff is extremely helpful. And Gail has
17 made such a big impact on the efficiency since she's
18 been back.
19 But, you know, Matthew mentioned having done
20 the paper version. And we used to do the paper
21 version. My -- our students would graduate on
22 Friday and they'd have a temporary license issued to
23 them on Wednesday, the following week. And now
24 we're like a month later and maybe we've got one.
25 So -- and it's, you know, there's no consistency.

1 So -- and, you know, I know that that's not you.
2 JAMES FUTCH: Well --
3 KATHLEEN DROTAR, Ph.D.: It's things that --
4 JAMES FUTCH: We're all the Department of
5 Health.
6 KATHLEEN DROTAR, Ph.D.: We're thinking things
7 that could be worked out and we'll be happy to help.
8 JAMES FUTCH: My brain was educated in physics
9 and I like to see things simple. And usually, the
10 simplest solution is the correct one. I don't
11 really suffer much with all the niceties of the
12 human interactions and the different levels of
13 management, and why can't we have this and why can't
14 we have that. And then you throw lawyers into it --
15 I apologize to anyone who also has a law degree.
16 But if I could make it so by my human actions, I
17 would do so. But anyway.
18 So that was one of the issues. And the other
19 one Christen had raised was the business by which
20 the RA has to report their supervisory relationship.
21 Let me close this out and jump to a different
22 section here.
23 And Matt, actually you were part of this
24 discussion, I appreciate very much. Christen
25 referenced what the PA used to report the

1 supervisory relationships with their physicians.
2 And essentially asked the question, can we do that?
3 Can we do it that way? They currently send
4 something in on a piece of paper that meets a
5 regulation that says they have to have license
6 number, name of the physician, license number for
7 themselves and their name. Has to be done within 30
8 days and basically that's, you know, that's it. You
9 have to have that.
10 And so, we reached out to Stephen again, and he
11 came back with some screen shots of what that
12 physician assistant mechanism for reporting the
13 supervisory relationship in the same online system
14 we were just talking about for the other purposes,
15 what that looks like. And so this is -- and Matt,
16 since you've actually had to do this, feel free to
17 jump in here and tell me if this is wrong or tell me
18 this is right or whatever needs to be said.
19 But Stephen has identified some areas --
20 obviously, it's a search screen. You put in where
21 you're looking for the licenses. This is one down
22 here on number two where a license for
23 supervising -- for a person that is a supervising
24 physician is entered already. And you could delete
25 it if that relationship is gone. So this is Dr. --

1 I don't know if this is a real doctor's name or not.
2 I apologize if it's a real doctor. Stephen usually
3 puts in fake information for this kind of stuff, but
4 we'll pretend it's a real doctor. I'm also kind of
5 afraid to read some of these because when IT people
6 go to make up fake names, you never know quite what
7 kind of sense of humor they have.
8 So this is where you would enter trying to find
9 somebody new. This is somebody who's already there
10 that you could get rid of. If you did want to go
11 add someone new, this is the interface that you'd
12 use. Add related license they call it. The system
13 is for establishing relationships between licenses.
14 In this case, a supervisory relationship.
15 You apparently have a drop down here that you
16 can put in the kinds of relationship. He didn't
17 give us, I think, all of what those were. In this
18 case, he just picked supervised by an MD. Your role
19 is the supervised PA. And then you'd put the
20 license number, for example, of your new supervising
21 physician here to go to look them up.
22 And in this case, they've added a relationship
23 for whatever this license number 123456. I'm pretty
24 sure that one's fake. And so, here's the new person
25 that's been added for this PA as another supervising

1 physician. This Dr. Smith. Seems pretty simple.
2 MATTHEW WALSER: It is. It's a little bit
3 clunky when you first get on there. Like, I have
4 30 something supervising physicians on my list.
5 JAMES FUTCH: You have 30 listed on this screen
6 right here?
7 MATTHEW WALSER: Yeah. And I constantly,
8 as we have people on ortho that come and go,
9 fellows that may work ortho care and I'm
10 under their supervision when I work an after-hours
11 shift, I have to kind of stay on top of who's
12 around and who's not around and our business
13 office does a good emailing every PA,his
14 doctor is leaving on this date and this doctor is
15 coming.· Update your license, it's on you.·
16 I get on this thing every couple months and make
17 sure the doctors that are on there are actually
18 people that work with.
19 JAMES FUTCH: Do you have a certain time-frame
20 that you have to report?
21 MATTHEW WALSER: Thirty days. So it will not
22 let you add anybody until the day of that you --
23 like, if they start working on --
24 JAMES FUTCH: I see. You can't do that ahead
25 of time.

1 MATTHEW WALSER: October 1st, I can't go in
2 September, even though I know they are already
3 credentialed, they have a license, I can't add them
4 to my list until the day they get there. And then I
5 have 30 days to do that. So -- and then if they
6 leave, I have 30 days to get them off.
7 JAMES FUTCH: My guess is when the Florida
8 Radiological Society got the radiologist assistant
9 added in Florida back in '08 whenever it was, we
10 must have had the PA relationship in mind because
11 the same 30, 30-day time period we put in the regs.
12 back then.
13 I do have one question. So when you add the
14 physician, does the physician get any kind of
15 notification?
16 MATTHEW WALSER: I don't think so.
17 JAMES FUTCH: That's interesting.
18 MATTHEW WALSER: So if you go to their license,
19 like if you go to Florida license look up and find
20 them, there are a couple tabs. There's general
21 info. There are --
22 JAMES FUTCH: Practice location.
23 MATTHEW WALSER: Subordinate practitioners.
24 I'm a subordinate to the physicians and they make
25 sure they remind me of that.

1 (Laughter)
2 MATTHEW WALSER: It's a running joke. But --
3 and then it will have a list of all of the PAs that
4 work under, you know, under their supervision. And
5 then it has, like, secondary locations, you know, if
6 they work in different offices.
7 JAMES FUTCH: So the public or whoever can
8 actually go and see it.
9 MATTHEW WALSER: Absolutely. Absolutely.
10 JAMES FUTCH: All right.
11 MARK SEDDON: Do you have any facilities to
12 look at? Do their medical staff offices for
13 privileging have any tie into this at all for you?
14 I guess as a support PA whatever, whatever, whatever
15 classification, category they provide privileges
16 usual, it's under a specific physician. How does
17 that tie to this?
18 MATTHEW WALSER: I'm not sure I understand your
19 question. Like in terms of facility or --
20 MARK SEDDON: Yeah, for privileges at a
21 hospital or facility.
22 MATTHEW WALSER: Yeah. So when we get, like at
23 UF Health, I'm privileged to work at all of the
24 different towers and the off-site locations, if I
25 request that. So we have a office in Leesburg.

1 Well, I'm never going to go to Leesburg so I don't
2 have privileges to go to Leesburg. But that's
3 really through the hospital. And then as far as the
4 State goes, any place where I'm practicing medicine,
5 I have to let them know that. And so it's on me to
6 let the State know that I'm going to be at the three
7 hospital towers, student health care center,
8 athletics is another one. That's kind of off site
9 for us.
10 MARK SEDDON: Right.
11 MATTHEW WALSER: But I don't think -- I mean,
12 like the --
13 MARK SEDDON: You don't have to let the
14 facility know your supervising -- who your
15 supervising physician is?
16 MATTHEW WALSER: Yes. They, they have a list.
17 MARK SEDDON: They have a list.
18 MATTHEW WALSER: They have a list.
19 MARK SEDDON: As a licensee, you're
20 responsible, as a PA, you're responsible for
21 notifying the State, updating that and also
22 notifying your facilities?
23 MATTHEW WALSER: Yeah. I think the department
24 business office does that for us. And most
25 certainly every two years when I go through

1 re-credentialing, I get a packet and they say, hey,
2 make sure this is correct and sign it and send it
3 back to me.
4 I've been there 13 years and I pretty much just
5 look over it and sign it and send it back, so -- I
6 don't know where they get that list. I guess they
7 get it from the website. It looks like a print out
8 from the website.
9 JAMES FUTCH: The online license look up?
10 MATTHEW WALSER: Mm-hmm.
11 JAMES FUTCH: They're adding new stuff to that
12 all the time. It's always kind of surprising to go
13 see what's there.
14 What do you see, other than this entry when you
15 go to click this drop down?
16 MATTHEW WALSER: DO or MD, or DO.
17 JAMES FUTCH: That's the only two? The
18 feedback from this, this is very minimal cost. We
19 essentially use -- if we change nothing, except for,
20 you know, of course, would be there an entry here
21 that says supervised by, I'm assuming MD or DO.
22 Your role would be supervised RA.
23 MATTHEW WALSER: RA.
24 JAMES FUTCH: Or RRA, whatever language we're
25 putting in there. And that would be -- there's a

1 little cost. But it's like a maintenance fee that's
2 very minimal per year to the subcontractor, not like
3 a programming fee, which we could absorb that. That
4 would be really --
5 MATTHEW WALSER: I will tell you as an end
6 user, for me to go and swap out people, it is so
7 much better than the way it used to be. Before, I
8 had to have a typed form. I couldn't write it out.
9 It was typed. Had to be typed. So you have to go
10 find a typewriter. And then I had to figure out how
11 to use that thing.
12 (Laughter).
13 MATTHEW WALSER: Make sure it was actually, I
14 think it's on the right line. It was a disaster.
15 Every time a doctor would come or go, I would have
16 to start all over. And then I'd have to mail it to
17 Tallahassee and I just hope it got to the right
18 place. Not really knowing. Because it's my
19 license. And if somebody ever came for an audit,
20 and that last copy didn't get there, then it's some
21 ridiculous fine. I know people have been fined for
22 not taking people off their list. And it was
23 hundreds and hundreds of dollars.
24 JAMES FUTCH: Okay.
25 MATTHEW WALSER: Some doctor moves to Atlanta,

1 Georgia and he just happens to still be on your
2 list, and you're not working under him or being
3 supervised by him, but he's still on the list, it's
4 still hundreds -- it's like 300 and some dollars or
5 more per person.
6 REBECCA McFADDEN: Wow.
7 MATTHEW WALSER: It's serious. I don't want to
8 get caught like that.
9 JAMES FUTCH: So if it's -- the sense of the
10 council, we'll proceed along with this path and see
11 if we can get this added for the 34 -- 32 licensed
12 professionals. I'm sure the number will change when
13 the reimbursement changes at the federal level.
14 I, unfortunately, can't tell Christen.
15 She's -- I don't know if you want to mention this
16 now or you want to save it for the member sections.
17 But Christen is home with her new baby and has
18 expressed an interest -- her term is up, along with
19 some of the other folks, in about two weeks or so
20 and she's not going to -- doesn't want to serve
21 again at this point. So we'll have a new RA next
22 time if we can get the paperwork through.
23 REBECCA McFADDEN: Do you have someone in mind?
24 JAMES FUTCH: We always go back to the society.
25 REBECCA McFADDEN: Right. There's a society

1 that does that.
2 JAMES FUTCH: In this case, it's FRS. It's the
3 Florida Radiologic Society. The radiologists. And
4 they've -- I think they've sent someone, very
5 preliminary. But I think it might actually be
6 someone from University of Florida.
7 REBECCA McFADDEN: He's over here cracking a
8 joke. This guy over here in Gainesville. That's
9 how they do it up there. He's over there -- there's
10 only 31 operations because there's only one out. So
11 I think I'd share that tidbit with you guys.
12 MATTHEW WALSER: I was trying not to get that
13 on the Record.
14 REBECCA McFADDEN: That's okay. You have now
15 been put on record.
16 JAMES FUTCH: So that's it for action items
17 related to MqA and MqA updates. Any questions?
18 Bring an MqA person next time?
19 (Laughter)
20 RANDY SCHENKMAN, CHAIRPERSON: I think being
21 that, you know, you feel this is so much easier, it
22 makes a lot of sense to simplify the whole process
23 instead of keeping it so complicated.
24 MATTHEW WALSER: I think somebody asked the
25 question does the physician know -- do they ever get

1 an alert that I've put them on my supervisory list?
2 I don't know the answer to that but I, I think that
3 would -- I mean, if I were a physician, I would want
4 to know that because I could go in there and type
5 anybody's name in there and have them be a
6 supervising physician for me. And that, liability
7 wise -- I mean, for the people I actually work
8 under, it's no big deal for them. They know me.
9 But I could put six doctors from the private group
10 across town on my list and they would have no idea.
11 Or a PA that has worked for us, and maybe she only
12 worked for us or he worked for us, I'm thinking of
13 somebody specifically, for six months and they
14 weren't very good and we had to give them an
15 opportunity to get better somewhere else, and if
16 they don't take the physician off their list, that's
17 a liability for them, too. And I just don't know if
18 they get that alert. I don't think they do.
19 MARK SEDDON: That's what I was thinking that
20 for hospital privileging, that might tie into that.
21 I think that is more formal with you, in regards to
22 when they have folks working underneath another
23 physician at a hospital. So it's usually the
24 removing privileges is pretty quick at a hospital
25 setting.

1 MATTHEW WALSER: Getting them is not quick.
2 MARK SEDDON: No, it's not quick. Removing is
3 pretty quick. That's why I was thinking about
4 notification if someone does lose their
5 authorization.
6 MATTHEW WALSER: Yeah. I think that would be
7 interesting because when I do, when I make a change,
8 within seconds, I get an e-mail that says I have
9 changed something.
10 MARK SEDDON: Right.
11 MATTHEW WALSER: Or something has changed on my
12 license. It's an automated response. So maybe the
13 physicians get an e-mail and they, you know, they
14 also get 700 other e-mails in a day and it just gets
15 lost.
16 JAMES FUTCH: Matt, do you have perhaps any of
17 your supervising physicians you might be able to
18 make that inquiry and let us know?
19 MATTHEW WALSER: Maybe I could drop somebody
20 off and then add somebody and see what happens.
21 JAMES FUTCH: And I will say this: Whatever
22 happens with the PAs, they're not going to change it
23 for the RAs. We'll be using this exactly in the
24 same, you know, way, words, backgrounds, IT coding
25 and all the rest of it. Because they're not going

1 to recreate this particular wheel for a profession
2 of 32 people.
3 MATTHEW WALSER: I think ultimately, it works
4 pretty good. It's way better than paper.
5 JAMES FUTCH: That's all for that option.
6 RANDY SCHENKMAN, CHAIRPERSON: Okay. So now we
7 have Clark.
8 CLARK ELDREDGE: All right. Well, as Cindy
9 mentioned, we currently have no vacancies in the
10 program, which is a good thing. I believe at this
11 time last year, during renewals, we were down two
12 regulatory specialists while we had a hurricane to
13 deal with and that kind of put a big crimp in the
14 processing of the renewals.
15 Currently, we have, you know, over 1900 --
16 19,300 facilities registered and over 58,300
17 machines. For MqSA facilities, that makes up 576,
18 up from the 564 last year. There were contract for
19 last year in the licensees.
20 Chiropractic facilities about 1500; dental
21 about 8,000.
22 All of the medical which, you know, diagnostic
23 imaging centers, hospitals, doctors, mobile,
24 osteopathic, about 5,000.
25 Educational, industrial total about 1200

1 facilities.
2 Registrations dealing with therapy, about 500,
3 but that includes both the primary accelerator and
4 the associated imaging with the accelerators. And,
5 of course, the specific x-ray therapy systems.
6 Podiatry, about 640. Veterinary is about
7 2,000.
8 So as of last Friday, we actually processed
9 about 2600 of the renewals. And so that's pretty
10 good for the first two weeks.
11 We worked on a training for, statewide training
12 for the MqSA inspectors September 10th and 11th at
13 the Orlando lab, so we brought them in. We had FDA
14 staff show up. They had just finished auditing a
15 number of our inspectors prior to that and so they
16 actually used the results of that audit to help
17 guide their training to kind of reinforce their --
18 help pick up weaknesses, anything they identified.
19 Overall, the comments, we've yet to receive a
20 formal response from FDA after their audits, but
21 overall, the comments, or the things -- the
22 evaluation of the inspectors was positive.
23 Mr. Seddon, with his wonderful folks, helped us
24 out. If you wouldn't mind telling them what you did
25 for the MqSA training for us.

1 MARK SEDDON: Yes. So one of the requested
2 training topics was to focus on the physics report
3 and Q and A with physicists for the inspectors as
4 far as what they should be looking when they're
5 doing an inspection or evaluation of a site for
6 mammography.
7 So I provided a team of five of us physicists,
8 diagnostic physicists to do some training. We went
9 over some of the key issues they should be looking
10 for when they're reviewing a physics report from the
11 different vendors and what they should be expecting
12 in a physics report as far as what is a good physics
13 report.
14 They actually spent about a hour and a half
15 with Q and A for what type of questions they had
16 technically for the different type of equipment
17 that's out there. Obviously, with the technology
18 change with the 3D, contrast enhanced, all the newer
19 technology, mammography, it's changed a lot back
20 from the days of screen and film.
21 So we spent about two-and-a-half hours total of
22 training with all the mammography inspectors and I
23 think overall, it was well received. And good for
24 them to have that opportunity to ask questions when
25 they don't really have a chance to.

1 CLARK ELDREDGE: It was great. We actually had
2 staff, when you get your staff writing e-mails about
3 how wonderful the training was, it means -- made a
4 big impression on them, and they really appreciated
5 it. So we did get some good feedback on all that.
6 Okay. So we actually have a legislative
7 proposal that's made it to downtown at this point.
8 Page --
9 JAMES FUTCH: Third page after the agenda.
10 Looks like this (indicating).
11 CLARK ELDREDGE: So the purpose of this, the
12 main goal of this, of course, is to try to kind of
13 bring right -- refocus how registration is currently
14 done. The focus in registration right now is who's
15 operating the machine, not the particular risk or
16 hazards. Because let's go back to, you know, 1980,
17 and who was operating the machine may very well have
18 represented the risk and hazards. But the way the
19 registration is written, it hasn't really allowed
20 the fact that dentists are adopting CT machines and
21 podiatrists are adopting CTs and there are more
22 dental machines in hospitals and things these days
23 which are whole different, you know. So there's
24 a -- the approach is changing. So we're trying to,
25 in the language, focus on the machine and its use as

1 opposed to who's operating the machine.
2 JAMES FUTCH: Or the kind of facility.
3 CLARK ELDREDGE: Or the kind of facility,
4 right.
5 The other part of this is, of course, the fees
6 were -- we removed the hard fees in the statute and
7 just referencing the whole thing that the fees need
8 to be adjusted for how much it costs to do the work,
9 which it says in the statute but then they didn't,
10 again, put the limits on it. We've been at
11 statutory limits for quite some time now.
12 And then a third part of this was language that
13 actually adopts personal health and safety benefits
14 of direct radiation exposure into the statute. And
15 to clarify that, that's sort of an operational way
16 we've been using radiation, directly exposing
17 individual radiation for decades, was the fact that,
18 you know, there should be some health benefit to the
19 exposure. You just don't put somebody in the beam
20 for whatever.
21 So the categories, let's see here. Or the way
22 the categories -- if we -- page three is -- yeah.
23 So let me make sure I've got this right starting
24 point. Okay.
25 Actually, the second page of this. Radiation

1 machines that are -- have a peak voltage greater
2 than 80 kV, are used to intentionally expose natural
3 persons to the useful beam and used in but not
4 limited to, and then the parts that were in there
5 before. So basically, this describes what was the
6 machine. You know, diagnostic machines, et cetera,
7 at the time. And really, that's what they were
8 going for was what was the machines used by doctors
9 and whatnot. But of course, as I say, those
10 machines have been moved for other uses.
11 The next section, radiation machines that have
12 a peak voltage equal less than the 80 kV and used to
13 intentionally expose natural persons to the useful
14 beam, and used in but not limited to, and again, the
15 practice is dentistry and podiatry you put there.
16 Basically saying that these machines should be
17 inspected at the same frequency they were before.
18 Radiation machines which are used for
19 therapeutic purposes and the healing arts. Now, we
20 do have a whole, you know, veterinarians have
21 started taking good old human therapeutic machines
22 and putting in animals. Now, they are operating the
23 machines the same way. They basically have the same
24 risks to the personnel, you know, whatever. So I
25 don't see at this point, why they should have been

1 treated -- currently, they've all agreed to be
2 registered and treated the same way. The
3 veterinarians have agreed to be registered and
4 treated the same way as therapeutic machines for
5 human exposure. So accelerating from that point, so
6 we're putting those together and having the same
7 annual inspection.
8 Then we've got accelerators, do not expose
9 natural persons to the useful beam. Good old
10 industrial. Radiation machines that are not
11 intended to expose natural persons. In general, but
12 they're not covered anywhere else, so that will
13 cover all veterinary, diagnostic, all the general
14 industrial stuff as it is now. And so the
15 difference throughout here, the theme is whether or
16 not you're putting somebody in the useful beam or
17 not.
18 Because we really don't -- honestly, we don't
19 care how the machine is operating if you're not
20 putting a person in front of it. That's a problem
21 for the person using it to make sure it's getting
22 the result that they want. While when you actually
23 put a human in the beam, then we do worry about that
24 you're doing the least exposure to get the most
25 information.

1 And I've got their machines that meet more than
2 one of the criteria listed shall be inspected the
3 most frequent schedule applicable.
4 So now, we've added a maintenance thing. This
5 is in line with the significant advent of the
6 internet and purchasing parts and pieces online.
7 This is really geared towards the folks who are
8 doctors and small diagnostic facilities that really
9 aren't maintaining their equipment to any particular
10 standard. And reports we receive from concerned
11 employees and things at these facilities about the
12 source of the materials and the fact that if they're
13 not purchasing equipment that actually is, you know,
14 you can get stuff from China and everywhere they
15 will say be equivalent, but is it really equivalent
16 equipment. And putting the onus on the operator to
17 make sure they're taking due diligence in purchasing
18 a machine or this equipment for -- again, this is
19 only direct exposure of people supposed to be in the
20 beam. Make sure it's going to not validate --
21 invalidate their FDA approvals and things like that
22 for the machines.
23 And then the next page is talking about the --
24 adopting the standard for there needs to be health.
25 Now because since this whole statute was written, we

1 now have security exposures of persons. We then
2 want to insure that the individuals being exposed
3 for security purposes are actually also, it's a
4 health benefit for them. I mean, a life safety
5 benefit. That they're not just being exposed to a
6 radiation dose when it's not a direct life safety
7 event to the individual exposed. And, you know, and
8 that would allow for security, transmission x-ray
9 security inspections of humans -- of persons when
10 there's a reason for their own benefit for that
11 investigation. That inspection.
12 JAMES FUTCH: But not shoe fitting
13 fluoroscopes.
14 CLARK ELDREDGE: Excuse me?
15 JAMES FUTCH: But not shoe fitting
16 fluoroscopes.
17 CLARK ELDREDGE: Not shoe fitting fluoroscopes,
18 right. Not shoe fitting fluoroscopes, yes.
19 So that's what we've got. It's actually
20 downtown. It's supposedly been -- we have not
21 actually seen a bill that's been attached to, but
22 it's supposedly put in, it's in bill form somewhere.
23 We haven't just seen it. We haven't seen it
24 actually show up on the legislatures -- legislative
25 system yet.

1 RANDY SCHENKMAN, CHAIRPERSON: Do the machines
2 in the airports get checked regularly?
3 CLARK ELDREDGE: Which machines in the
4 airports?
5 RANDY SCHENKMAN, CHAIRPERSON: The ones --
6 MARK SEDDON: Security.
7 RANDY SCHENKMAN, CHAIRPERSON: -- that you have
8 to stand and do this.
9 CLARK ELDREDGE: Those are millimeter waves and
10 are outside our jurisdictions. They're not ionizing.
11 ADAM WEAVER: They are not ionizing.
12 CLARK ELDREDGE: When they first came out with
13 those, they were actually -- they were the
14 backscatter x-ray machines. There was enough public
15 human cry that the federal government backtracked
16 and had all those pulled out and put in the
17 millimeter waves instead.
18 NICHOLAS PLAXTON, M.D.: What is that
19 technology? Is it millimeter wave?
20 CLARK ELDREDGE: It's microwave.
21 NICHOLAS PLAXTON, M.D.: Oh, microwave.
22 ADAM WEAVER: You have to get -- do you have a
23 proposed list of the standards that you're -- the
24 national or consensus standards that you're looking
25 at?

1 CLARK ELDREDGE: Basically, everything the
2 medical community thinks is a good idea.
3 ADAM WEAVER: So you're talking ANSI, AAPM,
4 whatever.
5 CLARK ELDREDGE: Whatever. AAPM has a bunch of
6 good stuff. That's, you know, there's actually even
7 stuff from Joint Commission and stuff about how to
8 maintain your machine. So we're quite acceptable
9 and open to what is considered. As I say, as long
10 as it's what the manufacturer says this thing needs
11 to be calibrated whatever, you know. That's going
12 to be --
13 ADAM WEAVER: I guess my concern is more of the
14 industrial side.
15 CLARK ELDREDGE: It doesn't apply to
16 industrial. It won't apply to industrial. It's
17 only --
18 ADAM WEAVER: You said there is a --
19 CLARK ELDREDGE: The machines where humans are
20 put in the beam intentionally.
21 MARK SEDDON: Number six.
22 ADAM WEAVER: There is one for not intended to
23 expose.
24 CLARK ELDREDGE: It's not intended to expose
25 natural persons.

1 ADAM WEAVER: You're just saying it's going to
2 be inspected.
3 CLARK ELDREDGE: Oh, no. This is -- the
4 standards are for the maintenance of the machines
5 that are intended to be exposed to natural persons.
6 That's where that was --
7 MARK SEDDON: I think Adam's question is for
8 number six, basically, it seems to imply any machine
9 not intended for use on people is to be inspected at
10 least once every three years.
11 CLARK ELDREDGE: Years, which is what it is
12 right now.
13 ADAM WEAVER: What standard? Are you going to
14 change the standards? Are you going to -- we're
15 using the FDA now. The 10, 21 CFR 1040. Are we
16 changing the exposure limits to something newer?
17 I'm just worrying because there's some older
18 equipment, especially in a university, like maybe
19 some industrial machines.
20 CLARK ELDREDGE: There should be no effect.
21 Any of this should not affect any of that. Because
22 the inspection -- the inspection standards are --
23 we're trying to maintain the inspection standards
24 the same for all the current equipment. Other than,
25 again, devices that meet these -- we might have some

1 hospital machines that only need inspected every
2 four years, et cetera. Some dental that may have to
3 move up to every two. But other than that, all the
4 industrial machines that people aren't in the beam,
5 nothing should be affected. And then we have the
6 maintenance schedule type stuff, maintaining the
7 equipment. That is only for machines that people
8 are put in the -- that humans are stuck in the beam.
9 And if you're not putting people in a beam, then the
10 industrial research --
11 ADAM WEAVER: Okay. I mean, like for instance,
12 a veterinarian -- not a -- you have a C Arm. That's
13 designed for humans, but it's not used on humans.
14 CLARK ELDREDGE: Right. If you're using it as
15 industrial, it's not affected.
16 ADAM WEAVER: Okay. I'm just wondering,
17 everybody always wonders how do we inspect that
18 machine? Are we going to treat it like it's a human
19 one and lower the dose rates and those kinds of
20 things?
21 CLARK ELDREDGE: No.
22 MARK SEDDON: I guess that's a good question.
23 So the C Arm, which is, so the vendor would provide,
24 like it's a medical, because it's an FDA device.
25 CLARK ELDREDGE: Once you stop using it on

1 humans, from regulatory, it's industrial. We don't
2 care how you use it. But then we're always worried
3 about operator protection.
4 MARK SEDDON: Right.
5 ADAM WEAVER: Right.
6 CLARK ELDREDGE: But not the --
7 MARK SEDDON: Not the outputs.
8 CLARK ELDREDGE: At that point, it's whatever
9 makes the best quality for your own purposes and
10 that's outside our concern. When you're --
11 ADAM WEAVER: I wanted to --
12 MARK SEDDON: How you register it would
13 determine.
14 CLARK ELDREDGE: Yeah. How you initially
15 registered it.
16 ADAM WEAVER: Okay. I'm sure we're not the
17 only place that has --
18 CLARK ELDREDGE: Yeah, yeah. That's somebody
19 if you wanted to do artwork, could get any
20 diagnostic machine, to put their, you know, scatter
21 their materials to say x-ray, and make x-ray art
22 type thing and that would be --
23 ADAM WEAVER: And I guess, in regard to, you
24 know, we've getting more and more cabinets. I mean,
25 these new x-ray machines are getting so small.

1 MARK SEDDON: That's the question just with the
2 cabinets, the specimen imaging systems that are --
3 ADAM WEAVER: Yeah.
4 MARK SEDDON: -- all those have to be
5 registered as, I think that's a question people
6 always have. I don't think we get an answer
7 sometimes. Is that industrial or is it medical
8 since you're using it on patient tissue but not
9 technically on patients.
10 ADAM WEAVER: Right. If they x-ray tissue
11 taken out of a person.
12 CLARK ELDREDGE: Yeah, at this point, if it's
13 not a living, complete human --
14 MARK SEDDON: It's industrial.
15 CLARK ELDREDGE: It's industrial.
16 MARK SEDDON: Okay.
17 ADAM WEAVER: So it goes to how you register
18 it. Okay. All right. I mean, I don't know. You
19 may have -- like hospitals a lot of times just add
20 it.
21 MARK SEDDON: Everything to the one hospital
22 registration.
23 CLARK ELDREDGE: Yeah.
24 ADAM WEAVER: For pathology.
25 CLARK ELDREDGE: For convenience, you could

1 have multiple registrations, but it's for the
2 convenience of the hospital and it may be actually a
3 lot more cost effective for them to do that, than
4 having us only come in once every couple years to
5 interfere with their operations rather than having
6 somebody come in every other odd year to look at
7 their other industrial machines.
8 ADAM WEAVER: I guess the only other question I
9 have is what is the fee schedule going to look like?
10 Now it's pretty well spelled out. Have you guys
11 worked on the fee schedule?
12 CLARK ELDREDGE: We don't anticipate touching
13 the fee schedule any time soon just because there's
14 no cost justification to the agency at this point.
15 In fact, that's in our bill analysis because, you
16 know, if technology changes somehow that would
17 impact us, if we have to buy some more equipment or
18 something, something that impacts the cost of the
19 agency, that's the only time we look at the fee
20 schedule.
21 ADAM WEAVER: Right.
22 CLARK ELDREDGE: And the fact that while we
23 actually should, you know, if we wanted to be truly
24 technically correct or whatever on this, we would
25 actually look to try to adjust to make sure that all

1 the machines that meet this were actually properly
2 registered at their fees.
3 The cost to the -- the cost, you know, looking
4 at the total numbers involved, the total number of
5 CTs and dental, the total number of medical,
6 whatever. In the hospitals, both the dental and the
7 cabinet biopsy machines, things like that, I
8 don't -- the numbers involved really don't look like
9 any of the cost shifting would really justify the
10 effort and whatnot. That the efficiencies gained
11 from it wouldn't -- would benefit -- would be
12 greater than the cost actually implement the changes
13 to the folks overall.
14 You know, the fact that you would actually have
15 to worry about setting up your own internal tracking
16 within your own facilities and that overhead costs
17 to implement those as well as, we just don't see, at
18 this point, that it would make a, you know, net
19 benefit to society to adjust for those differences.
20 But if things change radically, it would.
21 ADAM WEAVER: Yeah, you justify it.
22 CLARK ELDREDGE: Yeah, justify it. At this
23 point, there's no financial justification for it.
24 ADAM WEAVER: Because I just -- so there's
25 going to be a separate or there is currently a

1 separate fee schedule somewhere else in the --
2 CLARK ELDREDGE: We -- yeah. We would -- no.
3 The schedule, we just take our current schedule and
4 make sure -- it's in the rule and we wouldn't change
5 it.
6 ADAM WEAVER: It's in the rule now. You just,
7 you just removed it by the type of machine.
8 CLARK ELDREDGE: -- machine. Yeah, we just, we
9 would keep it the same.
10 ADAM WEAVER: You do mention --
11 CLARK ELDREDGE: Again, we'd adjust language in
12 the rule to reflect this, but we wouldn't -- we'd
13 still look at the, all the categories pretty much
14 stayed the same until there was some significant
15 enough change, but at this point we're hamstrung if
16 there was a change and we actually are seeing
17 progressive shifting in changes of uses of machines
18 between categories and --
19 ADAM WEAVER: Yeah.
20 CLARK ELDREDGE: -- and the current way it's
21 written, it just doesn't allow for technological
22 change and shift.
23 MARK SEDDON: Since all of this is dependent
24 upon how somebody registers the machine, what type
25 of inspection enforcement or however you do it, to

1 confirm that people are actually registering things
2 properly? Because it seems like that is really now,
3 a lot of the responsibilities is going back on the
4 registration, properly registering the proper
5 categories.
6 Do you guys have -- I don't know. Is there
7 anything on the inspection side, your side that you
8 have some way to capture when machines aren't
9 registered?
10 CLARK ELDREDGE: When machines aren't
11 registered, period? Of course, that's the 2579,
12 1114 requirements from vendors who sell the
13 machines.
14 MARK SEDDON: Right. That is still --
15 CLARK ELDREDGE: Install machines.
16 MARK SEDDON: Install machines.
17 CLARK ELDREDGE: That's still there.
18 MARK SEDDON: Assuming that somebody submits
19 the 2579, I assume the process goes back to down to
20 you guys. Then if somebody registers that machine
21 under the proper category or there's a secondary
22 seller who sells it or doesn't -- specialized
23 cabinetry, C Arm, you probably have -- the variance
24 used to be in the hospital and transferred over, I
25 would assume.

1 ADAM WEAVER: Yeah. It actually depends on
2 where they get the money. Sometimes it's a
3 refurbished machine, but sometimes it's a new one.
4 A lot of times we just get them based on whoever has
5 got the money and then a lot of times, the machine
6 goes away when the money dries up. Research.
7 CLARK ELDREDGE: There are issues currently
8 right now with industrial users that we probably
9 have some lack of registration or lack of compliance
10 that we've been looking to figuring out how best to
11 address. Any industrial users, gold industry,
12 precious metal folks. We did have the case a couple
13 years ago where a dealer down in south Florida had
14 been holding his jewelry for three years and
15 claiming to do several hundred or more shots a year
16 into his hand and after three years, he started
17 having neurological problems in his hand. And he
18 had bought it from a guy down the street. His XRF.
19 ADAM WEAVER: Just a handheld?
20 CLARK ELDREDGE: Little handheld.
21 ADAM WEAVER: Because those are being made in
22 foreign countries that are not -- they're easy to
23 buy off of EBay or equivalent systems.
24 CLARK ELDREDGE: Yeah. And so, yes. That's a
25 whole, a whole area we're trying to figure out how

1 best to --
2 ADAM WEAVER: The registration --
3 CLARK ELDREDGE: -- to get that under control.
4 And but with the internet, that's another part of
5 the technology thing that's outstripping or --
6 ADAM WEAVER: Yes. You've had a few of those
7 people trying to come in and use, especially, well,
8 we're not going to talk lasers now.
9 JAMES FUTCH: You're holding --
10 ADAM WEAVER: You're holding a laser.
11 JAMES FUTCH: You made me.
12 CLARK ELDREDGE: I wonder if mine --
13 ADAM WEAVER: Where did you buy that from?
14 JAMES FUTCH: Are they as cheap as these?
15 Because when they get as cheap as these, you've
16 really got a problem. I'm sorry, laser pointer. So
17 it says it's FDA compliant with 21 CFR 1440. It
18 says it's a Class 3A laser system with less than 5
19 mW output. My green laser, Clark has got one that
20 says the same thing. We noticed one day that seemed
21 awfully bright. And we measured it and it was 45
22 mW, which is Class 3B.
23 ADAM WEAVER: A lot of times they don't filter
24 out the blue. It's very powerful.
25 CLARK ELDREDGE: Yeah.

1 JAMES FUTCH: This is green. Are the x-ray,
2 the small x-ray systems --
3 ADAM WEAVER: You don't see very much of it,
4 but we do have, like we have a guy in anthropology
5 who just bought a dental x-ray machine. And we
6 don't have any idea where he got it from. It's a
7 Diox, D-I-O-X. And he thought he could, you know,
8 hold it by hand and x-ray skulls. Not living
9 people. But he also didn't want to bring it
10 overseas, which is another issue for us in regard to
11 export control and those kinds of things.
12 CLARK ELDREDGE: We've had a dentist who
13 surrendered his handheld x-ray machine to us because
14 he purchased it off EBay. There was no serial
15 number on it. No way to provide proof that it was
16 either American, you know, built for the U.S. market
17 or not; and so therefore, he surrendered it since he
18 couldn't use it.
19 ADAM WEAVER: Which is a challenge on both
20 ends. The user and the --
21 JAMES FUTCH: Have we seen, like, deliberate
22 fake labeling to pretend that it met U.S.
23 requirements yet?
24 CLARK ELDREDGE: No. Well, not anybody's
25 recognized.

1 JAMES FUTCH: I've seen that with lasers.
2 ADAM WEAVER: You see it a lot with lasers. I
3 don't think I've seen it -- we have an x-ray machine
4 from Russia we won't let them use. It's registered,
5 but it doesn't have all the interlocks that we would
6 like. We've run out of money, so we still have the
7 machine in storage.
8 MARK SEDDON: Will electronic bracket stily
9 have a separate section?
10 CLARK ELDREDGE: It's still EB. I forgot to
11 list how many EBs there. It's like eight. There
12 are not that many. I had them in the wrong
13 category. There are eight. Eight registrations and
14 eight machines.
15 ADAM WEAVER: Good luck getting the bill
16 through. Cindy could get it.
17 CYNTHIA BECKER: I'm sure.
18 JAMES FUTCH: The other thing is even if the
19 law passes, when it comes time to implement or
20 change anything in the regulations, Chapter 120 is
21 still going to apply.
22 CLARK ELDREDGE: Right.
23 JAMES FUTCH: We still have, unless it's been
24 repealed, the monetary limits of what is it?
25 250,000 in any one year, a million over four.

1 CLARK ELDREDGE: Right.
2 JAMES FUTCH: And you've got multipliers that's
3 going to --
4 CLARK ELDREDGE: Would kick out anything that
5 was --
6 JAMES FUTCH: -- put you into that category for
7 sure. So you're going to have to go back to the --
8 in the rule adoption process. That's going to have
9 to go back through the Legislature.
10 CLARK ELDREDGE: And that's certainly part of
11 the whole thing is that reason -- and part of that
12 whole thing about, it would have to be enough of a
13 economic benefit for all parties to implement any
14 changes to the fees or shifting around.
15 ADAM WEAVER: Right.
16 CLARK ELDREDGE: Again, if we did initial
17 thing, assuming, again, assuming we still had enough
18 to operate on it, would strictly be revenue neutral
19 as a whole would be the goal. Not to, as I say,
20 just to appropriately charge people as necessary.
21 ADAM WEAVER: They don't want you to make
22 money.
23 CLARK ELDREDGE: No. And we're not here to
24 make money.
25 ADAM WEAVER: Right.

1 CLARK ELDREDGE: You know. That's -- we're
2 here to provide the service that was negotiated
3 between those who are being regulated and --
4 ADAM WEAVER: The counties that were doing it
5 on their own, set their own schedules. Own fee
6 schedules a long time ago.
7 CLARK ELDREDGE: I believe last time I
8 mentioned the medical events that occurred right
9 before the meeting. So we've got more information
10 on those.
11 Moving on to medical events.
12 So we had three medical events involving
13 breasts that all happened in April. So in one of
14 them, the physician ordered a simulation for the
15 wrong breast. And it went through until 19th, 20th
16 fraction before it was discovered that it was the
17 wrong side of the body.
18 In the interim, there were two sets of review
19 forms for -- having a different doctor and a
20 different therapist who signed off, saying they
21 looked at the pathology reports and the treatment
22 plan. Which if they actually looked at the
23 pathology reports and looked at the treatment plan
24 and compared, they would have seen the pathology all
25 said --

1 JAMES FUTCH: The other side.
2 CLARK ELDREDGE: -- the other side. Of course,
3 then there -- the first was in the simulation order.
4 And the rest, the other time was three days after
5 treatment began, they were looking at the first
6 day's treatment and verifying things for the first
7 day's treatment.
8 There was also a physician who took over care
9 and began -- this is the physician who discovered
10 it, day 19 of 20, and suspended treatment. Actually
11 started signing all the forms -- order forms for the
12 stuff five days before treatment started. So
13 there's some question there of, if the physician was
14 signing everything five days before treatment
15 started, that how carefully they looked at it. So
16 there are five individuals, including the original
17 physician, who had an opportunity to, at times,
18 compare the pathology reports to the treatment
19 planning.
20 The facility, in their corrective actions,
21 proposed to add another layer of check of the
22 pathology versus the treatment planning. We are
23 currently reviewing that and are -- do not think
24 that actually addresses the solution and are
25 planning that they request to reevaluate that. The

1 way we're requesting that is the legal group to
2 address that.
3 MARK SEDDON: Question. Was the treatment plan
4 to the wrong breast or was it the simulation and
5 treatment delivery to the wrong breast?
6 CLARK ELDREDGE: Well, it started with the
7 simulation and just carried on through, so
8 everything was the wrong plan, the wrong breast. It
9 started with the physician, well, right breast and
10 all of a sudden, wrote everything left and
11 everything got carried on through.
12 RANDY SCHENKMAN, CHAIRPERSON: You think the
13 patient would say something.
14 CLARK ELDREDGE: Well --
15 MARK SEDDON: A lot of times patients will
16 catch that.
17 CLARK ELDREDGE: Yeah. That's what happened
18 the next two. The patient caught it. In this case,
19 it was, yeah, that just got carried through. But of
20 course, the person had cancer on both sides. Had
21 had mastectomies on both sides and things like that,
22 so there was a mystery of involvement.
23 Then we had two cases where an electron boost
24 treatment was done to the incorrect scars. In one
25 case -- well, in both cases, of course, there are

1 multiple biopsy and lumpectomy scars in the general
2 target areas.
3 In the first case, the target scar was actually
4 faint and hard to distinguish. The physician did
5 not provide sufficient descriptive guidance to the
6 therapist where it was to be placed. Where the
7 target scar was. In fact, they noted in their
8 comments in the investigation that, yeah, I should
9 have -- it was hard to see and hard to find. The
10 new scar was actually the faintest. All right?
11 The patient -- and so the, the therapist put
12 the wire on the wrong scar. The doctor then did all
13 the treatment planning around the wire as the
14 target, et cetera, for the boost treatment and
15 whatnot. And patient notified the therapist, prior
16 to the second boost treatment, saying, um, I think
17 that's the wrong spot. And so, there was 200
18 centigray electron boost treatment to the wrong
19 location in that case.
20 Similar thing but slightly different.
21 Electron boost treatment. Again, wrong scar.
22 Again, multiple scars in the general treatment area.
23 However, the target scar was in the supraclavicular
24 region. The CT tech placed the wire on top of a
25 scar on top of the breast. So -- and then again,

1 this was sent to the doctor for treatment -- for
2 doing the volume treatment plan, et cetera. Looking
3 at that and of course, you can look at an x-ray and
4 you can see that's a significant difference in
5 distance. And so, there were some places here where
6 it could've been caught rather early on. While in
7 the first, the first one they were very close
8 together.
9 And so, the guidance provided, there was one
10 statement, one line about there was something on the
11 CT scanning and their superclavicle is on there, but
12 it was still kind of weak on the communication with
13 the tech. But it could've been caught by the tech
14 as well.
15 And again, the patient said, I think that was
16 the wrong spot. And so, after the first treatment,
17 the second day comes in and, are you sure that was
18 the right place? And that was stopped there. So
19 those were those two cases.
20 Any questions or -- okay.
21 MARK SEDDON: I should -- so when they did the
22 patient set up, there was a physician actually
23 present?
24 CLARK ELDREDGE: That's actually what their
25 current -- thank you. The recommendations there is

1 actually on this case, they're going to actually
2 get -- this facility had -- they neither, neither
3 cases was there any boost treatment SOP. There was
4 nothing about -- now they're actually going to make
5 sure that either in the modeling, in the CT sim, the
6 physicians are actually involved where the wire's
7 placed and verifies the patient -- verifies wire
8 placement before, before the modeling.
9 MARK SEDDON: Yeah. That's a smart thing to
10 do.
11 CLARK ELDREDGE: Yeah. So that actually looks
12 like it would directly address.
13 MARK SEDDON: Not that physicians are
14 infallible, as you say. If it's close to each other
15 and there's multiple scars, they have trouble as
16 well. But at least you have another set of eyes
17 looking.
18 CLARK ELDREDGE: Yeah. We have -- okay. So
19 we've got some updates to information notices. The
20 one here is actually talking about allowed exposure
21 of humans to useful beam of radiation machine.
22 Again, following along with the idea of medical
23 benefit. And this is -- should be two pages after
24 where you were before.
25 So in the broader topic of this whole guidance,

1 this part goes back to, you know, the DEXA folks.
2 DEXAFit and their use of a physician in Michigan
3 who's writing orders for people who come in to a
4 non-medical facility to pay for a body mass index
5 measurement using a DEXA machine. And within that,
6 another case is we actually have currently
7 registered, registered three of these facilities.
8 One of which it is the actual office of a licensed
9 practitioner. And so the licensed practitioner is
10 on site working with the people. So that's fine.
11 The other one, there is a licensed practitioner
12 who actually has set up a protocol within his
13 facility with PAs and whatnot that actually will,
14 they will actually make appropriate medical
15 determination prior to issuing it and they are
16 actually responsible for looking at the results.
17 Even though he's remote to the facility, they
18 actually will be forwarded to them and have his
19 folks and staff, you know, as appropriately under
20 the practice standards, evaluate and provide the
21 results back to the individual being screened.
22 Appropriate medical guidance.
23 The third facility actually is under review
24 because while the physician involved in that
25 facility had signed a -- can't say the word right

1 now. I hate this -- a settlement agreement with the
2 State, saying that they would implement those types
3 of models where the individual coming into the
4 facility, you know, information would be provided to
5 the physician to make sure that it's a medical
6 determination and then the result would be sent to
7 the physician for him to review, provide the
8 guidance, and sent back.
9 It turned out that the -- upon inspection, that
10 the radiologic technologist was actually operating
11 the machine without knowing that there was any order
12 available. And when the results were provided and
13 they were then turning around and going over the
14 results with the individual receiving the x-ray, in
15 violation of the agreement. And so that's with our
16 legal staff on the appropriate response. And we
17 hopefully will be meeting with them next week to
18 follow through on that violation of the settlement
19 agreement.
20 We also have another facility currently
21 offering free heart CTs.
22 ADAM WEAVER: Free heart CTs?
23 CLARK ELDREDGE: Free heart CTs. And as a
24 prelude to having you sign a five-year contract for
25 full body CTs.

1 MATTHEW WALSER: Huh?
2 KATHLEEN DROTAR, Ph.D.: What?
3 CLARK ELDREDGE: When the facility first came
4 to our radar -- this company came to our radar, they
5 were actually contracting with diagnostic centers to
6 apply the CTs. They then applied for registration
7 of their own to operate their own CT, at which point
8 we asked them for clarification and they've since
9 declined. They've since pulled their registration
10 or their thing for their own facility saying it was
11 uneconomically feasible at this point. After
12 showing them the requirements and how, you know,
13 there has to be the continual loop of a doctor who
14 is providing the intent -- looking at he was a
15 patient, determining his medical need for some
16 concern that the physician had, then the x-ray being
17 performed, and then using that in your care. But
18 they're still performing it with the -- through the
19 secondary contracted facilities. And so we're
20 still -- we're currently reviewing how to approach
21 those since they've chosen not to do it on their own
22 after I guess looking at the rules.
23 So a part of this is -- the language here is
24 after having the more recent CT one, I'm not sure
25 that this is -- I'm trying to figure out if we need

1 to reevaluate this draft version we have here.
2 Although it was approved as a draft, it was then
3 pulled back for publishing for that.
4 So currently, a licensed practitioner operating
5 within their practice standards determines the
6 medical need for the exposure and orders -- this is
7 the lower set of bullets on the front page.
8 That medical need includes an evaluation of the
9 health risk from the exposure versus the medical
10 benefits, the information gained from the exposure,
11 the licensed practitioner, licensed radiologic
12 technologist exposes the patient. The licensed
13 practitioner operating within the corrective
14 standards, reviews and interprets the results of
15 exposure, provides the medical information to the
16 patient, uses the medical care of the patient.
17 I guess that final sentence still captures that
18 enough. Uses the medical care of the patient
19 because, of course, in this case, the persons
20 offering this contract for the five years of full
21 body CTs, there's a doctor in the area who is
22 signing these without ever meeting with the patients
23 or the individuals receiving the CTs. And then the
24 CT is sent to a contract group out of state who then
25 reviews the CTs. Does it -- and then they basically

1 blind send the results to the primary care physician
2 of the individual receiving the CT.
3 In looking at the Yelp reviews, et cetera, for
4 this facility, there are a lot of comments like my
5 doctor wouldn't let me get one. I finally found
6 somebody who would give me one.
7 Again, we're not trying to say they shouldn't
8 be done. You know, currently, there is the proposed
9 guidance. I don't know if it's been actually, ALA,
10 I'm not sure anybody else has moved on it, where
11 the -- where screening CTs for lung cancer for 30
12 day -- 30 year pack-a-day smokers. So there's been
13 evaluation that's -- this is a proposal, I don't
14 know how far it's gone through any of the medical
15 groups. Where they actually are saying that if
16 you've been smoking a pack a day for 30 years, your
17 risk of lung cancer is such that you should consider
18 screening for lung cancer using a CT. Now, of
19 course, they specify low-dose CTs in this case
20 because of the improvement in CT technology that's
21 lowering the exposures involved in the CTs. It's
22 also part of that --
23 MARK SEDDON: -- has a lung screening program
24 through the HCR, that's a low-dose screening program
25 that requires you to have less than 3 -- I don't

1 know what the does limit is -- actually less than 3
2 Gy.
3 There's a category that you have to meet to be
4 part of the program. So that seems more medical
5 focused than this may be.
6 CLARK ELDREDGE: Right, yeah.
7 MARK SEDDON: You're talking more like folks
8 who want to have, like, calcium screening and lung
9 screening. Screening type exams, correct?
10 CLARK ELDREDGE: Screening, yeah. And so
11 that's, and so actually that was part of it, whether
12 or not in our own rules, I guess this is where
13 looking at, whether or not we need -- looking at
14 language to beef up in our rules and actually
15 mention, you know -- currently our rules say -- I
16 guess I need to switch over my -- where is it?
17 Okay.
18 James, do you want to pass the -- no, actually
19 we can look at it on this page. Sorry. The page
20 after 640-5.101 has a healing arts definition, which
21 means the professions concerned with the diagnosis
22 and treatment of human and animal maladies,
23 including the practice of medicine, dentistry,
24 veterinary medicine, osteopathy, chiropractic and
25 naturopathy. Say that too many times.

1 Then 5.501, healing arts self-referrals means
2 testing human beings using x-ray machines for the
3 detection, evaluation of health conditions when such
4 tests are not specifically ordered by a licensed
5 practitioner of the healing arts legally authorized
6 to prescribe x-rays for purposes of diagnose and
7 treatment, diagnose and medical treatment.
8 And then under 502, administrative controls,
9 individuals shall not be exposed to the useful beam
10 except for healing arts purposes unless such
11 exposure has been authorized by a licensed
12 practitioner of the healing arts.
13 And it specifically prohibits the following:
14 Exposure of an individual for training purposes;
15 healing arts self-referral except for mammography,
16 which is (a)11. Advertisement of free exams unless
17 the advertisement states a determination will be
18 needed to be made prior to the x-ray examination.
19 So that's actually something else we're working
20 on with these individuals offering free heart CTs is
21 to get them to actually say that explicitly.
22 And then so, putting in, finding some
23 appropriate language for saying appropriate usage of
24 the term screening and whatnot, to try to clarify
25 the blind screening, if we want to call it blind

1 screening, or bulk screening of individuals using
2 x-rays is inappropriate, but it should be on an
3 individual determination by a physician or unless
4 it's guidance from appropriate medical -- what did
5 we call ACR or --
6 RANDY SCHENKMAN, CHAIRPERSON: Societies.
7 CLARK ELDREDGE: Society.
8 MARK SEDDON: Society. ALA or American Lung
9 Association. Because the ALA, they have that 30
10 pack a year history.
11 CLARK ELDREDGE: Something like that, yeah.
12 MARK SEDDON: Yeah. Age 55 to 80, 30 pack a
13 year history of smoking and are a current smoker, or
14 quit within the last 15 years, you are eligible for
15 the initial cancer screening.
16 CLARK ELDREDGE: So those would be, you know,
17 the appropriate uses. And actually put in a
18 prohibition against screening unless, again, if your
19 doctor figures, I'm not about to say any doctor
20 thinks everybody, you know, that anybody at a
21 certain condition in their care should certainly
22 have certain screenings. That's within their
23 professional judgment, but --
24 RANDY SCHENKMAN, CHAIRPERSON: Then they go
25 some place with a prescription, which is the

1 doctor's approval of the doctor's order of having
2 this done. They aren't just walking in and getting
3 it done.
4 CLARK ELDREDGE: Right. Well, other than --
5 well, there's the approval, right. But the
6 physician shouldn't even, you know, we need to
7 tighten up that a physician isn't selling his
8 signature. Because let's, you know, let's be
9 honest. That's what was happening with the opioid
10 crisis. Physicians were selling their signatures
11 and so we have physicians selling signatures without
12 any due cause or evaluation or using it in treatment
13 of their patients.
14 MARK SEDDON: I think a lot of the restrictions
15 with ALA. Those are all for reimbursement for
16 Medicare; that kind of stuff. So I think it's
17 self-pay.
18 CLARK ELDREDGE: These are all self-pay.
19 MARK SEDDON: That's where you might be having
20 all the --
21 ADAM WEAVER: Insurance companies won't approve
22 it.
23 MARK SEDDON: Yeah, insurance companies have
24 strict standards and there's where you have --
25 RANDY SCHENKMAN: Right.

1 NICHOLAS PLAXTON, M.D.: The VA, so we have
2 the -- we've instituted this low dose chest x-ray --
3 or not chest x-ray. CT for our patients that have
4 that history. So the doctors will be aware of that
5 and they order them. I mean, usually you're into a
6 grab bag of, they usually end up having all kinds of
7 issues. They have nodules. Now they get a PET/CT.
8 They have a work up. Things are getting cut out.
9 It's not lightly, you know, you go into that.
10 There's a, you know, after 30 packs a year of
11 smoking, you're going to have something. So your
12 lungs look like Swiss cheese. You're going to have
13 nodules.
14 But that -- I don't see how that applies to
15 like, it sounds like these are just people that are
16 paranoid and they want to get a whole body scan to
17 kind of keep an update on themselves. They want to
18 pay cash. They don't want a doctor involved at all,
19 right?
20 CLARK ELDREDGE: Right.
21 NICHOLAS PLAXTON, M.D.: That's the whole idea.
22 But I think, I mean, is that even allowed or are
23 they allowed to do that?
24 CLARK ELDREDGE: Well, but there's a doctor
25 who's, again, signing the scripts.

1 NICHOLAS PLAXTON, M.D.: Someone is signing?
2 CLARK ELDREDGE: Someone signing them sight
3 unseen. Just approving them.
4 NICHOLAS PLAXTON, M.D.: You've got to find out
5 who those doctors are, I would think --
6 MATTHEW WALSER: There's no patient/physician
7 relationship.
8 CLARK ELDREDGE: There's no established
9 patient/physician relationship.
10 NICHOLAS PLAXTON, M.D.: Those doctors --
11 MATTHEW WALSER: They should be reprimanded.
12 NICHOLAS PLAXTON, M.D.: They should be
13 reprimanded for their actions. If you could find
14 out who those doctors are.
15 CLARK ELDREDGE: When we visited the spot, we
16 did it with MqA. So they're currently --
17 NICHOLAS PLAXTON, M.D.: Involved.
18 CLARK ELDREDGE: -- involved.
19 MATTHEW WALSER: Were they in-state doctors,
20 like in the State of Florida?
21 CLARK ELDREDGE: Yes. As I said, the DEXA guy
22 was out of state. The CT scan is in state. All of
23 them are state licensed.
24 KATHLEEN DROTAR, Ph.D.: If I wanted to have
25 that type of scan, then I could just go in and say,

1 I'm, you know, I'm self-pay and, yeah, I've been
2 smoking for 30 years. And nobody is going to check,
3 just go through and check off on a list and, okay,
4 now you qualify. You can go have it done.
5 NICHOLAS PLAXTON, M.D.: If you're going to do
6 it live, that would be a chest x-ray, not a whole
7 body CT.
8 KATHLEEN DROTAR, Ph.D.: Well, people walk in
9 for anything that's free and now I can get it
10 checked, you know. And the oversight --
11 NICHOLAS PLAXTON, M.D.: Yeah.
12 KATHLEEN DROTAR, Ph.D.: -- needs to be there.
13 ADAM WEAVER: If you're self-paying, they're
14 not going to turn you away.
15 KATHLEEN DROTAR, Ph.D.: Yeah. Here's my
16 money.
17 NICHOLAS PLAXTON, M.D.: Yeah.
18 RANDY SCHENKMAN, CHAIRPERSON: And you have one
19 more category here?
20 CLARK ELDREDGE: Our friends at the Department
21 of Corrections have submitted a request to, request
22 use of technology on all persons entering and
23 exiting the secure perimeter.
24 So this is a transmission x-ray security
25 scanner. This is currently permitted under

1 administrative code, although this is not actually
2 one of the uses recognized in the Florida Statute.
3 But under Florida Statutes, we do have the, sort of
4 the responsibility for use, expanding the safe use
5 of radiation or making sure, not restricting
6 anything.
7 But the previous thing is actually for looking
8 for contraband hidden inside the digestive tract is
9 the purpose of this. They want to expand it to
10 everybody, whether or not there is any real risk of
11 them smuggling anything in the digestive tract.
12 We have -- our current draft response is
13 explaining that the reason we approved it was for
14 somebody who would have the opportunity to bring
15 something into a jail and be in there unsupervised
16 enough they could remove it from their digestive
17 tract to have contraband enter the facility in that
18 manner and there's all their technologies out there
19 you could use for quick screening of individuals
20 with things hidden on their persons, not in their
21 persons, such as the millimeter wave systems and/or
22 the backscatter x-rays that they could certainly
23 look at requesting or using. The millimeter has no
24 effect outside of regulation. The backscatter would
25 be up to our regulation purview; and that therefore,

1 we do not think this is appropriate use.
2 Plus, things like they don't -- they're not, do
3 not state what the secure perimeter is. Is that the
4 fence around the outside of the jail? Is that the
5 most inner, you know, behind multiple locked levels
6 of where the inmates are kept? At what point do
7 they determine that?
8 They don't say anything again about here about
9 the opportunity for supervised or unsupervised time
10 inside their perimeter. And why would they need to
11 use this on somebody who is, you know, if somebody
12 is going to the day room to visit somebody, how are
13 they supposed to be able to extract somebody,
14 something from their digestive track to pass off to
15 an inmate and then smuggle back through the rest of
16 the facility. How would that transaction happen?
17 ADAM WEAVER: What kind of -- is this a
18 fluoroscopic x-ray or what kind of --
19 CLARK ELDREDGE: No. It's a scanning x-ray.
20 They're operated similar to like a DEXA machine. I
21 mean, it's a single energy, but it's a pencil beam
22 or fan beam that goes across the person or if they
23 sit on a tray, they transfer in front of them with a
24 receptor behind them. It builds up a fairly explicit
25 image of their body or clear image of their body

1 through that.
2 ANSI does have a standard for this. How many
3 times somebody should be exposed to it; that type of
4 thing in here.
5 ADAM WEAVER: Is that where they -- this letter
6 got 1,000 scans per year?
7 CLARK ELDREDGE: Yeah. By the way, at the low
8 dose, which really doesn't show clearly what's
9 hidden in the colon or elsewhere in the digestive
10 tract. You really can't -- that's the thousand.
11 And if you bump it up to the energy, when you look
12 at the sample images provided by the manufacturer
13 and you really want to see what's any sort of close,
14 something, something similar to human tissue density
15 that might be in there, you know, you do need a
16 higher dose rate. And you get dropped down to like,
17 you know, 50, I think scans a year, something like
18 that, at those rates at the higher energy.
19 ADAM WEAVER: These machines have a fixed kV.
20 I mean, or does the operator adjust the kV and the
21 mA to -- for the image or does it just -- is it
22 automatic?
23 CLARK ELDREDGE: It's -- I believe they're
24 fixed. And -- but it's some sort of automatic,
25 adjustable exposure control.

1 ADAM WEAVER: So they're time based rather
2 than, okay.
3 CLARK ELDREDGE: Mm-hmm. But I can't be a
4 hundred per sure. I can't remember off the top of
5 my --
6 ADAM WEAVER: I'm wondering how are they --
7 CYNTHIA BECKER: How they adjust.
8 ADAM WEAVER: -- determining between low dose,
9 medium dose, high dose.
10 JAMES FUTCH: Clark, wasn't there a component
11 of this -- I remember reading the standard when this
12 first came up, at those higher levels, they're
13 supposed to track.
14 CLARK ELDREDGE: There's a requirement, they
15 track all exposure. They also did not address this
16 because we told them if you're talking about people,
17 but if you've got some of your -- but if you're
18 unfortunate to have family members in multiple
19 facilities, incarcerated multiple locations in the
20 state, or if you're a member -- an officer of the
21 court going in to visit multiple people in different
22 facilities in the State, they need to track that
23 across those -- they need to have a system to track
24 their exposure across all those facilities.
25 ADAM WEAVER: This isn't just for inmates.

1 This is also for visitors, perhaps.
2 CLARK ELDREDGE: This proposal is for anybody
3 crossing the line. Then again, the question is, how
4 much.
5 RANDY SCHENKMAN, CHAIRPERSON: Children and
6 pregnant women.
7 CLARK ELDREDGE: Children, pregnant women.
8 Well, in the second page, it says pregnant
9 individuals.
10 RANDY SCHENKMAN, CHAIRPERSON: Yeah, it has a
11 limitation, but then what does that mean? Once they
12 hit that, they can't go visit the person anymore?
13 CLARK ELDREDGE: They also say no scans will be
14 performed, but below that case-by-case consideration
15 would be determined by duty shift supervisor or
16 higher authority. Indicating that maybe will they
17 or won't they? Because it's unclear from this
18 special considerations whether or not they are truly
19 not going to scan minor children or pregnant
20 individuals.
21 KATHLEEN DROTAR, Ph.D.: How do they adjust the
22 dose?
23 NICHOLAS PLAXTON, M.D.: From just reading
24 that, it sounds like to me they would be like the
25 airport where they you would get a, you know,

1 old-fashioned pat down and not the x-ray machine.
2 CLARK ELDREDGE: Yeah. Which is --
3 NICHOLAS PLAXTON, M.D.: Of course, that
4 doesn't, you can't, you know, I guess they could
5 have something -- they swallowed something. There's
6 no way to find that.
7 CLARK ELDREDGE: Right. The same point, if you
8 swallow something, you have to have the opportunity
9 to expel it. In order, again, that requires you to
10 be unsupervised in there for some extended period,
11 you know, in order to --
12 NICHOLAS PLAXTON, M.D.: Yeah. People must be
13 doing it because this seems to be a problem.
14 CLARK ELDREDGE: Well, again, I do not believe
15 that that's the -- even though they list huge -- in
16 their paperwork, they talked about how many
17 contraband recoveries. They did not split it
18 between hidden on the person versus hidden inside
19 the person and that's not clear in any of their
20 statistics of, you know; therefore, again, you don't
21 need transmission x-rays to look for things hidden
22 on a person. And so you don't need to be exposing
23 those individuals to those.
24 And then as I say, the health and safety idea
25 here, who's truly exposed to the risk of -- from the

1 benefit, risk benefit, if the individual, you
2 know -- what am I trying to say here?
3 Somebody going in to visit a loved one in the
4 day room, so to speak. What risk are they from the
5 drugs and stuff that maybe actually inmates are
6 taking behind the security, inside behind the next
7 level interior, security. Or the shives, weapons
8 and things like that.
9 So if you're x-raying these people coming in
10 who aren't necessarily themselves exposed to the
11 danger of the things at the next layer in, are
12 you -- why is this, you know, you're giving them an
13 exposure to a known carcinogen for what personal
14 health benefit for them? Or life safety benefit,
15 you know, is for transmission x-ray. So, you know.
16 NICHOLAS PLAXTON, M.D.: Are they using the
17 millimeter wave or the backscatter right now or --
18 CLARK ELDREDGE: No, they are just using --
19 because the whole trick is what's hidden in the
20 inmates' colons.
21 NICHOLAS PLAXTON, M.D.: They don't have those
22 others instituted at all?
23 CLARK ELDREDGE: No. They just want -- you can
24 also consider if there's a fiduciary consideration
25 here, monetary consideration of the fact that that

1 would require more -- another piece of equipment, so
2 they want to multi-use the piece of equipment,
3 whether or not it's appropriate to do that.
4 JAMES FUTCH: Would they use the transmission
5 machine in all situations, when backscatter would
6 be, would've been acceptable for --
7 CLARK ELDREDGE: Yeah, would've done the
8 equivalent. That's just -- they want to use the
9 transmission for all purposes, for any search, they
10 are going to use the transmission. That's the whole
11 point.
12 ADAM WEAVER: These machines are smaller, less
13 you know, less expensive to run.
14 JAMES FUTCH: Yeah.
15 ADAM WEAVER: The backscatter machines,
16 computer, detectors, they always have to calibrate
17 it, align -- there's a lot of expense. These are
18 relatively simple machines. The operator, you know,
19 it's pretty easy to use on your screen. You just
20 see a picture. It's like the DEXA scan without the
21 dual energy.
22 RANDY SCHENKMAN, CHAIRPERSON: So where does
23 the State stand with this right now?
24 CLARK ELDREDGE: The current response is that
25 it's, you know, if you're exposing an individual

1 without any benefit to a carcinogen, without any
2 benefit to the individual for security purposes is
3 not appropriate. That the individual should be
4 receiving some sort of medical or life safety
5 benefit to the exposure. And so they need to show
6 us how that's supposed to occur.
7 NICHOLAS PLAXTON, M.D.: It sounds like
8 couldn't they do -- I mean, the visitors coming in,
9 can do like the backscatter technology or something
10 of that nature? Where it sounds like the inmates
11 are the ones that -- I mean, after they meet with
12 the people, they could be going through one of these
13 scanners because that does benefit them because
14 like, you know, whatever comes across that line can
15 be used against them or, you know.
16 CLARK ELDREDGE: Yeah, it could be either way
17 against them, you know.
18 NICHOLAS PLAXTON, M.D.: That's what I'm
19 saying. They could use the scanner for the inmates
20 but not for the visitors. That would make more
21 sense.
22 CYNTHIA BECKER: Right. That's why we approved
23 that part of the revised regulation but not for the
24 visitors or the employees. But I think from their
25 standpoint, they're saying that the contraband is

1 getting into their facility through the visitors and
2 through their employees. So that, I think, is where
3 they're coming from.
4 CLARK ELDREDGE: Again, they did not say what
5 categories of contraband.
6 CYNTHIA BECKER: Right.
7 CLARK ELDREDGE: I have -- hearsay is terrible,
8 but this was third-party story through the
9 grapevine. We do have an individual at the
10 Department of Health who did, who has worked in
11 the --
12 ADAM WEAVER: Corrections.
13 CLARK ELDREDGE: -- corrections and talked --
14 has told stories to someone else in our program
15 about, you know, people hiding a piece of wire or
16 piece of metal, but that's on their person. And
17 when they go into the visiting room whatever, give a
18 hug and the person is able to swipe it and transfer
19 to their body a piece of plastic, but it could be
20 fashioned into, again, some sort of weapon or thing
21 inside. But, you know, again, that doesn't address
22 what's the best use of these body scanners for this
23 type.
24 RANDY SCHENKMAN, CHAIRPERSON: Right.
25 CLARK ELDREDGE: -- for checking what's hidden

1 in the digestive tract. Again, I don't quite see
2 how in many of these persons, how they're able to
3 extract something from their digestive tract and
4 transfer it to another person, to then --
5 ADAM WEAVER: Mm-hmm. So you've asked for more
6 information?
7 CLARK ELDREDGE: Yeah. Well, we've said no
8 unless, you know, but it is a clarifying yes. You
9 know, what's the --
10 ADAM WEAVER: You want more clarification.
11 CLARK ELDREDGE: You've got to demonstrate how
12 it's benefiting the individuals that would be
13 exposed to it and why they actually need it as
14 opposed to other less intrusive or less -- the other
15 methodologies that are just as effective that do not
16 carry the carcinogenic risk.
17 We've been going on, and so that was actually
18 the last item on my list of --
19 RANDY SCHENKMAN, CHAIRPERSON: Okay. So are we
20 ready to break for lunch?
21 BRENDA ANDREWS: So we're suggesting to do what
22 we did last year. Just go over to the World of Beer
23 and it's right here on the complex. Unless someone
24 else wants to do something different.
25 CLARK ELDREDGE: For the Record, that is a

1 restaurant?
2 RANDY SCHENKMAN, CHAIRPERSON: Yes.
3 ADAM WEAVER: Do they serve food?
4 BRENDA ANDREWS: They have lots of food.
5 CLARK ELDREDGE: It's the only restaurant
6 within easy walking distance other than the one in
7 the hotel here.
8 ADAM WEAVER: Okay. Be back at 1:30?
9 RANDY SCHENKMAN, CHAIRPERSON: 1:30. Yep.
10 (Proceedings recessed at 12:18 p.m.)
11 (Proceedings resumed at 2:02 p.m.)
12 RANDY SCHENKMAN, CHAIRPERSON: So, Kathy?
13 KATHLEEN DROTAR, Ph.D.: James, are you going
14 to start?
15 JAMES FUTCH: Yeah. So let me throw in my two
16 cents since I have -- Kathy sent me some
17 correspondence, which is the essence of this e-mail
18 that I sent to several of you asking to check with
19 your facilities. But AAPM in April, issued a
20 position statement which essentially says gonadal
21 shielding should not routinely be used, again, due
22 to some technical and scientific reasons which we
23 couldn't go into. We have Mark here to explain some
24 of that.
25 And then ACR agreed with AAPM, essentially,

1 which is the second letter. We have all these
2 documents for anybody who hasn't seen them. Then
3 ASRT said, whoa, we don't think we need to move that
4 fast. We need to pay some more attention to the
5 educational community in the timeframe she was there
6 in the patient side of whether or not this is --
7 even if it's scientifically a hundred percent
8 accurate, we have to implement this. We have to
9 implement this in the patients in the real world and
10 teaching of rad techs and things like this. And so
11 AAPM, after the ASRT lack of endorsement, sent an
12 open letter to the community essentially saying --
13 these are all my words, my interpretation of it, not
14 Kathy's, essentially saying, well, you know, this is
15 the scientific basis. We think this is correct, but
16 we never intended this to be the be all end all.
17 This is a start of a dialogue with the community and
18 we need to hear from all aspects of the stakeholders
19 and they formed this CARES community to go forward
20 with that.
21 After we talked, Kathy and I put this together
22 and sent it to various members, many of whom
23 responded either verbally or in the case of Miss
24 Becky, actually put the PowerPoint presentation
25 together and queried many members of her own

1 facility and surrounding facilities and we have that
2 also back here to talk about as we work all this
3 together.
4 So is that good? Bounce it back to you.
5 KATHLEEN DROTAR, Ph.D.: Yes. Thank you. The
6 little packet you have sort of has that
7 correspondence as it evolved. And I don't know that
8 anybody outside of physicists really saw anything
9 until ACR then endorsed the position statement and
10 then everything sort of started blossoming. And
11 the -- one of the things I wanted to point out was
12 that there are -- with the original position
13 statement, there's several good reference articles
14 that are in support of those statements for the
15 position statement.
16 But what happened was that at the -- they
17 immediately had a facility who said, no more
18 shielding. So that sent up a red flag for us
19 because, you know, there's State regulations that
20 include shielding and specifically don't add on
21 fetal shielding. So that was a start of a
22 conversation with James and I.
23 I attended the ASRT annual meeting and at the
24 House of Delegates -- well, actually one of the
25 first things that happened was that Dr. Sal Martino,

1 the president of ASRT, got up and said, "Everybody
2 calm down. We're going to look at this. We're
3 going to be part of a community with AAPM. We're
4 going to find out because it not only affects what
5 technologists do, it affects what our educational
6 components are." That's just ASRT.
7 ARRT, with the examination and certification,
8 it's also, you know, whether the proper, proper
9 radiation safety and, you know, how do we address
10 these things. So it's more of ASRT, ARRT wanted to
11 take a position of what are we saying and, you know,
12 have some protocols for, you know, the best way to
13 do this.
14 And at the ASRT meeting, you know,
15 technologists had been, you know, shielding from the
16 time that I was a student that, you know, this is
17 what you do. You do shielding. And now it's like,
18 oh, it's okay not to do it.
19 The AAPM Article Two by Dr. Whitemarsh, stated
20 at the end of the article, that it should be up to
21 the technologist because they are the person that
22 can better define what they should do in that
23 particular instance. Also, that the patients are
24 used to being shielded. Patients don't want to --
25 you know, they want to know that they're safe and

1 they, you know, they've been indoctrinated also
2 with, you know, shield me.
3 And so there's a lot of questions I think to be
4 answered. And the CARES community is one that, that
5 Mark's familiar with. And as far as we know, they
6 have -- they're still gathering people. The people
7 that want to weigh in.
8 One of the things in Dr. Whitemarsh's article
9 was a compilation, I think, of several different
10 things, but I think the dose without shielding was
11 .08 mR to .009 mSv, which was the protection that,
12 you know, is a very small, very minimal dose. But
13 the intent of the article, though, was that it's not
14 the external shielding that's necessary because it's
15 really the internal radiation risk that is more of a
16 question and that the shielding doesn't stop that.
17 So --
18 MARK SEDDON: Right. So a little more
19 background. So this is an initial start because
20 there's some states in the country that have
21 requirements stating that you have to have shielding
22 available for patients. And so for years,
23 especially in some -- in the OR and CT areas, a lot
24 of times you don't shield and it's kind of an
25 accepted thing with physicists and the industry,

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

1 and causing a problem.
2 So the theory is that whatever is causing the
3 benefit could be potentially causing a problem if
4 you place the shields in the way. So that's kind of
5 the recommendation from the position statement.
6 KATHLEEN DROTAR, Ph.D.: Yeah. It was also
7 that with the digital equipment, that putting the
8 shielding close to the field would then throw off
9 the automatic exposure and you would actually be
10 significantly increasing --
11 MARK SEDDON: Increasing the dose. And also
12 for digital equipment, a lot of times, even if it
13 doesn't affect the dose, it fully affects post
14 processing because all that effects -- because those
15 who work with DR or CR, combination, it makes a
16 difference. You could be adversely affecting the
17 quality and having forced repeats. A lot of those
18 reasons go into why the statement came out.
19 As Kathy pointed out, a lot of people are
20 involved in changing a lot of different practices
21 across the board. So I think that's where the CARES
22 committee, which is, in essence, a committee
23 formed -- the acronym is like something just to make
24 it sound like cares. So it makes up the word cares.
25 But it's basically, I can't remember what it's

1 called. It's a committee that includes, like, ACR,
2 AAPM, HPS, ASRT, NCRP, CRCPD. To go ahead and be
3 part of the group discussion on how to best roll
4 this out.
5 And really, the focus from the CARES committee
6 is to try to educate because I think the feeling is,
7 we have a position statement so it's official from
8 some of the -- even in here I believe it states like
9 the ACR, HPS, AAPM, you know, all the other
10 organizations, they all have endorsed this as this
11 is the consensus and feeling within the community
12 and how to roll it out is really the question. How
13 to roll this out. This is what people are aware of
14 and how do we roll this out regulatory wise. How do
15 you roll it out. CRCPD is looking at this; NCRP is
16 looking at this.
17 KATHLEEN DROTAR, Ph.D.: NCRP, yeah. And it's
18 Communicating Advances in Radiation Education for
19 Shielding is what the CARES committee is.
20 So there was also a study that was done as part
21 of that, part of one of the reference articles of
22 the facilities in England, over 500 cases in a
23 retrospective study. And almost every -- it was
24 over a third of them were repeats because of the
25 shielding being incorrectly placed. So that was

1 another significant reason, I think.
2 MARK SEDDON: You guys might recall there was a
3 big push for patients getting mammograms done a few
4 years ago to use thyroid shields. Do you remember
5 that?
6 KATHLEEN DROTAR, Ph.D.: Yes.
7 MARK SEDDON: A certain doctor on a certain
8 T.V. show recommended it on cable T.V. so everyone
9 came, wanted to go have thyroshields. They started
10 using thyroshields. They are right here and all it
11 takes is for them to drop a little bit. Now
12 suddenly you're obscuring and having all the
13 repeats. So like, really in scatter mammography is
14 minimal. Nothing to the thyroid, in essence.
15 So one of the concepts we've used in the past
16 even, it may not be a real benefit to the patient,
17 but provides piece of mind. So you give them an
18 apron and they feel safer even though it doesn't
19 hurt anything. So if it's not hurting anything,
20 then it's okay. But we're now seeing that in some
21 cases, it does hurt things. So that's where I
22 believe the push is coming to try to change the
23 practice.
24 JAMES FUTCH: This is the section of Clark's
25 regulation that speaks to gonadal shields. And

1 essentially, everything says you're supposed to use
2 them except for this last little clause right here:
3 Except for cases in which this would interfere with
4 the diagnostic procedure.
5 And then Cindy or Clark, I forget which one of
6 you guys provided this, the notes from the --
7 CLARK ELDREDGE: CRCPD.
8 CYNTHIA BECKER: Yes.
9 JAMES FUTCH: -- the CRCPD, which is this one
10 here.
11 CYNTHIA BECKER: Yes.
12 JAMES FUTCH: So this is -- so this is a
13 conference call from September 3rd. So all the
14 states that have x-ray regs probably adopted them
15 from the suggested state regulations, at least when
16 they started and then modified from there. So
17 there's a commonality to the states' x-ray regs.
18 And so there's questions on how to handle a gonadal
19 shield from AAPM and you saw the states before that
20 are participating. You can read it for yourself.
21 KATHLEEN DROTAR, Ph.D.: That was a big
22 question with ASRT, what about state regulations,
23 you know. Are we teaching our students to do
24 something that is not acceptable by state and
25 federal regulations.

1 REBECCA McFADDEN: Well, I think it's kind of
2 open ended. It says if it isn't going to obscure
3 your exam, that kind of gives you that ability to
4 educate it in that manner, at this point, but, you
5 know, looking forward, you know, they're looking to
6 make that change.
7 KATHLEEN DROTAR, Ph.D.: But there was several
8 comments from different program directors and
9 doctors from different states whose facilities had
10 done the same thing that ours had and said, no more
11 shielding. So that's a difference when you get into
12 those gray areas.
13 REBECCA McFADDEN: Mm-hmm.
14 JAMES FUTCH: So it seems like we're dealing
15 with a situation which would normally, from a
16 scientific basis, if we started out this way, we
17 probably never would have done the requirement to
18 begin with if we had the same equipment that we have
19 now. But you have an installed base of both machine
20 operators and more importantly, the public and their
21 understanding and natural fears of radiation in
22 general to deal with.
23 And I don't know if any other members want to
24 jump in or if you want to, Becky, if you want to
25 show them the PowerPoint.

1 CYNTHIA BECKER: Sure. Do you have it on
2 your --
3 JAMES FUTCH: Yeah. I'll get it up.
4 REBECCA McFADDEN: So when I was asked, my
5 entity, to reach out to some of my colleagues in the
6 area. I just picked 20 people that I thought that,
7 you know, would be interested in reading the
8 information and providing me with some feedback. So
9 this is basically just a breakdown of the statement,
10 which you guys have already read that, which is what
11 I provided to them. Also just giving us a brief
12 look at what the acronyms are because it does
13 mention those several times, so for me, I had to go
14 and look and make sure I understood what all these
15 things were. So I just listed the agencies.
16 And then some of the feedback, basically, this
17 is just the timeline. In April 2019 is when the
18 AAPM released the position statement and then on May
19 30th, the ACR agreed with it. I just highlighted
20 the medical physicists and quality and safety,
21 they're going to be reviewing it in order to make
22 recommendations for alignment with the position
23 statement.
24 Then in July, more research was required by the
25 ASRT because they didn't feel comfortable

1 recommending the discontinuation of the patient
2 gonadal shielding and there was some more general
3 information about the ASRT, but I just kind of
4 highlighted that piece. Like, okay, hold on.
5 That's where they put the brakes on.
6 In August, the ASRT Board of Directors said
7 cannot endorse the proposal at that time and that
8 there were numerous questions and possible change.
9 And now moving forward, this is -- so the
10 information that you saw in the first slide was what
11 I provided to some of my colleagues in education, in
12 management and actual patient, just to kind of get
13 an idea what their thoughts are.
14 So this was an HCA hospital. She's the
15 manager. She works strictly under the director.
16 Her contracted physicist group endorses the
17 statement and they have already begun changing their
18 policies to reflect that. So she's in the north
19 central region of HCA. So that's one of our
20 supports.
21 Next we had a not supported. This is a person
22 who actually provided me with a story about his
23 child had -- he was born clubfoot and he had
24 multiple, multiple x-rays. And as a result of that,
25 he's not sure there was never no evidence, but he

1 felt that it was part of that could've been -- I
2 guess he died of a bone cancer later on and he felt
3 that that could have then contributed to that later
4 in life and he did die at age 20.
5 So -- and he is a physics instructor. He just
6 teaches the physics class and he is a radiographer
7 and he said he was -- until that time, he was going
8 to continue to use the shields. To teach his
9 students to shield. So he was very adamant of, you
10 know, because of that personal situation. He was
11 adamant not supported.
12 The next respondent was that they had agreed.
13 This an out-patient, multi-clinic supervisor, so she
14 does CT as well as supervise. I think there's seven
15 or eight different outpatient facilities that they
16 have CT in. And so, one of those questions that she
17 said, you know, that they agreed. They implemented
18 the new. They no longer shield the patients.
19 But then the question is -- and I wanted to ask
20 your opinion on this, Mark -- with the CTs and the
21 shielding. That's always been kind of hard for me
22 being that CT was my background. We were told to
23 wrap them front and back. Then we were told not to
24 do anything. Then to do the top and then to do the
25 bottom. I mean, it's always been such a variable.

1 I don't know what the recommendation is in the
2 medical community for that or what it is regarding
3 CT, but this was really just talking about
4 diagnostic imaging, so I did want to ask that
5 question.
6 MARK SEDDON: So CT is the same thing.
7 REBECCA McFADDEN: Same thing. Okay.
8 MARK SEDDON: I'd say probably the consensus to
9 not provide CT has been longer within the community.
10 Primarily just because it's --
11 REBECCA McFADDEN: It obscures all --
12 MARK SEDDON: Obscures -- it can really mess up
13 your -- the new CRT scans have dose modulation.
14 REBECCA McFADDEN: Right.
15 MARK SEDDON: But the only time if it's out of
16 field, and then in, you know, we still have some
17 places like -- well, especially, if it's
18 specifically requested by the patient for peace of
19 mind because they're used to it and I think that's
20 what I say a lot of times people still shield, it
21 doesn't hurt. The whole thing about the bouncing
22 ball inside the scatter tank, that doesn't really
23 exist. In compass scatter, you already scattered
24 the radiation to the point, it's not going to
25 scatter back.

1 REBECCA McFADDEN: Right. So it's not going
2 to -- like she was saying.
3 MARK SEDDON: Right. This is like low energy
4 you're talking about, yes. So that's not accurate,
5 yeah, because there used to be some --
6 REBECCA McFADDEN: These are their personal
7 responses, so I'm sure --
8 MARK SEDDON: That's not accurate, but I mean,
9 you know, that's been, I think it's seasonal, longer
10 been more discussed in the past.
11 Now, I will say that there has been for a while
12 for CT, you know, in plain shielding, business
13 shielding with the eyes and breast to reduce, that's
14 actually, it's not like the same as a lead shield.
15 It's actually business shielding, which is actually
16 intended to be scanned through. So it reduces the
17 dose to the body part. That's a different type of
18 shielding than which we're talking about here, which
19 is gonadal shielding. It's a piece of lead actually
20 completely stopping the radiation.
21 REBECCA McFADDEN: Okay. So that was the
22 response there and then discussion on the CT.
23 So this is a director of imaging services from
24 a hospital, obviously talking about the CR versus
25 the CT and the same question about never using the

1 shielding and the wrap, so we're all kind of coming
2 from the same place. But at the end of the day, we
3 all have our own personal professional feelings.
4 So his is basically the same. He started
5 talking about the reducing of different, you know,
6 with the lead and using non-medic exposures, the
7 gonadal apron's importance is outweighing the
8 benefits versus the risk.
9 So he basically concluded by saying in a
10 perfect digital world, what they are suggesting
11 makes sense. But as a side note, we recently
12 conducted a research inquiry on the uses of lead
13 wrap shields associated with CT and it was proven
14 that you should never shield the patient with a CT
15 scanner due to the scatter bouncing between the lead
16 shields internal to the patient. They don't have
17 their friends like Mark to explain that to us the
18 right way.
19 But he said, but in the -- I think in their
20 case isn't quite proven considering the facts, and
21 that there are many older technologies and CR
22 machines still in use today.
23 So having that being said, you know, there are
24 variances of machines and when we heard how many
25 there are out there, and if they're using the

1 technology that we all are using in some of the
2 larger hospitals.
3 So he was a not supported. I felt like from
4 his, you know, back and forth a little bit, I felt
5 like it was a not supported.
6 And then another one, they disagreed. That
7 this patient should be -- this is another educator.
8 Clinical coordinator. One of the large schools.
9 Shouldn't shield the exams. They felt like that it,
10 you know, again, I think the education portion of
11 it, that clinical coordinators, they're so, you
12 know, used to educating that and they don't want to
13 change that practice, you know, at least from my
14 observation and what I've pulled.
15 My next, conclusion, is basically it was a
16 split decision. I had twenty people I surveyed; I
17 got six responses. And it was 50/50 of supported
18 and not supported, which then justifies it, it is
19 going on the table for some discussion and some
20 collaboration, but I think the collaboration, I
21 agree, Mark, is about how we're going to educate the
22 community, the people who are utilizing these
23 practices and not just going to say, we're going to
24 make this statement it's going to be the new rule.
25 But it really has to be done in a different manner

1 and I think maybe even if they take it back to the
2 table, it will get out and maybe, you know, the
3 medical professional community in radiology will
4 adopt and, you know, move forward with that.
5 MARK SEDDON: I think that was the intent. The
6 initial position statement was more to say it's not
7 recommended anymore. And they recommended that
8 discontinue use, but not like an official, this is
9 now effective April 15th, you have to stop
10 shielding.
11 REBECCA McFADDEN: Yeah. Like no -- you can't
12 even sell a gonadal shield. I don't think that's
13 where we're at.
14 MARK SEDDON: This is position statement that
15 people use to justify whether to decide --
16 REBECCA McFADDEN: They are or they aren't.
17 KATHLEEN DROTAR, Ph.D.: I think the flip side
18 of that, I was thinking during all this discussion
19 was going on, was time for they couldn't shield
20 because it wouldn't have been appropriate to shield,
21 so it was like, okay. That was already done, you
22 know. That if you shield or don't shield, if you're
23 doing it properly, then it's okay, too. It may be
24 okay depending on the equipment, but certainly needs
25 to be looked at. And everything I think is going to

1 come down, it's going to start with the physicists,
2 it goes to the radiologists and then comes down to
3 the rest of us. That's the way that things usually
4 work. Because then the think tanks are there to
5 really investigate it and to see what should be
6 done.
7 MARK SEDDON: Yeah. I think one of the things
8 would be, because part of the data out there would
9 be, how many times do you have repeats or studies
10 compromised because of the fact that shielding is in
11 place.
12 REBECCA McFADDEN: Right.
13 MARK SEDDON: Does anyone really look at that
14 from -- in the imaging radiology world? I don't
15 think -- that's not real something honestly --
16 REBECCA McFADDEN: Repeats are difficult to
17 track as it is.
18 MARK SEDDON: Right.
19 REBECCA McFADDEN: I mean, I think we've had
20 conversations about that.
21 MARK SEDDON: Yes.
22 REBECCA McFADDEN: And with the equipment and
23 the digital world, I mean, we, of course, give you
24 software for a nice little fee to pull your repeats,
25 but that doesn't -- it's not like the physical

1 marker on the image we used to count back in the
2 days, you know, to see who's actually repeating
3 this.
4 MARK SEDDON: I think historically, people in a
5 lot of places have said, you know, I don't feel -- I
6 don't have to shield because I don't feel it's a big
7 benefit. But I may still shield because it makes
8 the patient feel more comfortable. It sounds like
9 some of the people educating, even the query, that
10 was the kind of the thing was like as a patient, I
11 feel more comfortable with my child being shielded.
12 REBECCA McFADDEN: And I think the statement
13 did cover that and said that it wouldn't be
14 questioned. I mean, you can still do that or you
15 can still shield. It's just we think that --
16 MARK SEDDON: We don't think it's a
17 requirement.
18 REBECCA McFADDEN: A requirement, right.
19 MARK SEDDON: I think it's really -- the
20 wording maybe could've been a little bit better.
21 KATHLEEN DROTAR, Ph.D.: I think the second
22 letter that got sent out --
23 MARK SEDDON: Actually clarifies better.
24 KATHLEEN DROTAR, Ph.D.: Yeah, it's a lot
25 clearer.

1 JAMES FUTCH: Since Mark Wroblewski isn't here,
2 he actually sent me an e-mail. Let me just read
3 that. Can you all read that? I'm sorry.
4 Anyway, it says, he heard a little bit about
5 this. He said their position -- he runs a clinic or
6 a couple clinics. He's also a basic machine
7 operator. He says, "our position has always been
8 safety first. We saw no reason to not shield them
9 and not interfere with the exam."
10 The second position has been to try assuage new
11 patient expectations. Mom and dad don't know who
12 the AAPM is, but have been told for years radiation
13 is bad, use shields when available. Until I have
14 overwhelming evidence that we shouldn't, I see no
15 reason to open the door. We get the x-ray, mom and
16 dad are happy and we've done more than the minimum."
17 So he fits into the category of folks that you
18 surveyed.
19 REBECCA McFADDEN: Mm-hmm.
20 JAMES FUTCH: It's interesting to me to see
21 AAPM putting the statement out and then so many
22 members of the radiation community and various
23 levels in fairly high positions having such
24 divergent viewpoints on this. Imagine what the
25 public is going to think. This one is going to go

1 on the news.
2 REBECCA McFADDEN: I think our point is our
3 physicists and our recommendations and they are
4 basically our final go to's.
5 KATHLEEN DROTAR, Ph.D.: Oh, absolutely.
6 REBECCA McFADDEN: And so, in my opinion, you
7 know, in 31 years I've been in radiography, I mean,
8 it always comes down to what does the physicists
9 require, request or need and that's how we operate.
10 Because they have that, that profession and
11 knowledge to tell us what is the best thing or best
12 practice, in my opinion.
13 RANDY SCHENKMAN, CHAIRPERSON: It seems like
14 it's a problem with education.
15 MARK SEDDON: Yes.
16 RANDY SCHENKMAN, CHAIRPERSON: That's what it
17 is across the board for everybody.
18 REBECCA McFADDEN: Right. It's education
19 everywhere, yeah.
20 RANDY SCHENKMAN, CHAIRPERSON: For the
21 physicians, for patients, for the techs, it's going
22 to be education that's going to, you know, decide
23 which way this is going to go. When people are
24 educated, they will say, okay, fine. I don't need
25 it. And actually, could be worse for me as opposed

1 to what they've always been taught up until now,
2 which is you've got to protect these areas. You
3 know, it's a different philosophy, but it's based on
4 education.
5 REBECCA McFADDEN: And it's based on the
6 equipment changes and how we are acquiring our
7 imaging now versus what we did years ago --
8 RANDY SCHENKMAN, CHAIRPERSON: Right.
9 REBECCA McFADDEN: -- when those parameters
10 were put into place.
11 MARK SEDDON: I think it's interesting that all
12 the physics organizations and most of the physician
13 organizations are in agreement or endorsing. The
14 folks that actually work with the patients are the
15 ones who are aware that this is going to be a
16 problem because we're the ones that actually see,
17 you know, the technologists and the educators. They
18 know what the patients, what their logic is and how
19 it's going to cause trouble.
20 JAMES FUTCH: If you have a parent who decides
21 not to have the image taken --
22 MARK SEDDON: Exactly.
23 JAMES FUTCH: -- because they don't want it
24 taken without some sort of a shield, then that's not
25 good, either.

1 MARK SEDDON: Exactly.
2 JAMES FUTCH: So I don't know if anybody else
3 had any input they want to provide Mark from --
4 MATTHEW WALSER: I talked to several people
5 over in the UF Health system. Some rad techs and
6 radiologists. Interestingly, there were two people
7 that didn't know anything about all of this
8 business.
9 JAMES FUTCH: The director and assistant
10 director?
11 (Laughter).
12 MATTHEW WALSER: They will remain nameless. I
13 did forward them the articles and they read them and
14 got back to me.
15 But pretty much after a big discussion,
16 everybody said -- there's actually a policy to
17 shield at UF Health and you know what it's like to
18 change policy. So right now, it is a policy to
19 shield unless it is interruptive of the exam. So
20 pretty much they said, if we're doing -- I didn't
21 get into the CT world, but just regular x-ray
22 technology -- that they said if we're doing a hip or
23 a pelvis, we don't shield and everything else we
24 shield.
25 So they, you know, at one point, they were

1 trying to shield one side to get the lateral on the
2 other. And they said that they were -- that this
3 was a while ago. That they would end up having to
4 repeat and that was way worse than just not
5 shielding. So if it's not a hip or a pelvis,
6 they're pretty much shielding.
7 KATHLEEN DROTAR, Ph.D.: I thought that I was
8 going to go back and find historic documents and --
9 because we shielded. And, you know, it's like, you
10 know, knowing that you push the exposure button, you
11 know, that you shield. And I could find nothing
12 anywhere except maybe some textbooks about how to
13 shield. Until I got to about 2008, and then it was
14 AAPM articles that questioned whether we should be
15 shielding or not when it wasn't necessary in certain
16 instances. So it's --
17 REBECCA McFADDEN: Maybe that was the automatic
18 exposure control era. Because they were all fixed
19 techniques and then when you get your AACs and
20 you're starting to use lead again, if you're off
21 center, your exposure is going to increase. And
22 that -- the automatic exposures came out probably
23 late 70s, early 80s, right? Like around that time?
24 Something like that.
25 KATHLEEN DROTAR, Ph.D.: Something like that.

1 So the consensus sort of from ASRT and what we had
2 decided was, as students or educators and having
3 students at facilities, you're their guest. So we
4 would be going with the policies set forth by that
5 facility. But still teaching our students, this is
6 what you do. And, you know, because it's a part of
7 their competencies because that's the way it's
8 built, until something happens that the curriculum
9 actually changes that, you know, real world.
10 JAMES FUTCH: So this is the current reg. and
11 this is the way the reg.'s going to stay for now, I
12 guess. Everybody seems to read this and think
13 there's enough room for either position.
14 REBECCA McFADDEN: Yeah, I do.
15 ALBERT TINEO: That's, yeah.
16 JAMES FUTCH: That's always a good regulation.
17 ALBERT TINEO: You can adjust your policies to
18 meet that requirement.
19 REBECCA McFADDEN: To meet that requirement.
20 ALBERT TINEO: You can go to the extreme or you
21 can go right in the middle and still be okay.
22 JAMES FUTCH: I do remember seeing one sentence
23 in that mountain of material, from which
24 organization I don't remember. But it said, in
25 April, the FDA announced that it would look at or

1 begin the process of removing the requirement to
2 require shielding.
3 KATHLEEN DROTAR, Ph.D.: I think it's on the
4 website, I believe.
5 ALBERT TINEO: It's interesting because not
6 last time, but the time before when the Joint
7 Commission came to review, I went -- when they go to
8 radiology, I go to see what they're looking for and
9 it was a pediatrician. They wanted to see x-ray
10 images of a pediatric patient. And what he was
11 looking for was the shield. So it's just a
12 interesting perspective of --
13 REBECCA McFADDEN: Maybe he just wanted to see
14 if you guys had it or not.
15 ALBERT TINEO: If we were shielding. But that
16 was about two years ago, so -- or at least coming
17 down in the area that you were looking for.
18 RANDY SCHENKMAN, CHAIRPERSON: Well, I wasn't
19 able to reach too many people, but at the hospital
20 that I had worked at, my understanding, just from
21 talking to the radiation protection officer there,
22 he said that they had not changed the shielding
23 practices yet, but they were sort of waiting to see
24 what the final outcome of the discussions, I think
25 with the CARES committee, were going to turn out to

1 be before they changed their policies.
2 JAMES FUTCH: Okay. Anybody else? All right.
3 KATHLEEN DROTAR, Ph.D.: I just thought it
4 would be important to bring the discussion here and
5 have it here to get that input from everybody and,
6 you know, I think we're here, you know. See what we
7 see.
8 JAMES FUTCH: We certainly have all the
9 documents and minutes and the conversation if
10 anybody needs to use it for educating or
11 referencing.
12 MARK SEDDON: I think, as you pointed out, the
13 regulation allows flexibility. So that's probably
14 the key take away.
15 KATHLEEN DROTAR, Ph.D.: Yes.
16 JAMES FUTCH: And if you hear anything more
17 from the ASRT world, especially --
18 KATHLEEN DROTAR, Ph.D.: I was hoping they
19 would have their meeting before this, but I don't
20 think it's until later.
21 JAMES FUTCH: Okay. My turn again?
22 RANDY SCHENKMAN, CHAIRPERSON: Your turn.
23 JAMES FUTCH: Okay. Actually Cindy, you
24 covered this one.
25 I just wanted to mention that Lynn Andresen,

1 who you saw at the last meeting or the meeting
2 before, was here with Ginny and she has moved on to
3 Kevin's section. She worked for me in 2005, 2006 in
4 the rad tech program prior to MqA, so when she came
5 back a couple years ago, it was kind of an
6 eye-opening experience for her. Oh, wow, what's
7 this MqA thing? She actually, if I remember right,
8 Clark, she started working for your section.
9 CLARK ELDREDGE: She worked for me all of two
10 weeks or something before she jumped back to work
11 for you. I'm not sure what that says but --
12 (Laughter)
13 ALBERT TINEO: Nothing personal.
14 JAMES FUTCH: No. But she is, I can't say
15 enough with her time, with us in my section.
16 Excellent work. You want to talk about a person who
17 burns the candle at both ends, her candle has four
18 different ends. It's always going. She's working
19 on her Master's in her spare time. I'm saying all
20 these nice things because if I still need to borrow
21 her occasionally --
22 (Laughter)
23 JAMES FUTCH: -- for certain things.
24 CLARK ELDREDGE: There is something coming up
25 in two weeks --

1 JAMES FUTCH: I saw that we have another.
2 CLARK ELDREDGE: -- we have another medical
3 event. No details yet. We got the call as we were
4 leaving town yesterday. So --
5 JAMES FUTCH: Okay. Moving on. So this week,
6 in fact, a couple days from now, Kelly Nesmith, who
7 many of you know is the coordinator for the rad tech
8 program, she's going to be traveling to Minneapolis
9 and ARRT does this CE consensus meeting. They used
10 to do this every couple years and then with all of
11 the new changes and requirements for what do they
12 call it? Continuous quality review, the CqR, you
13 get to relicense yourself every ten years, there
14 have been a lot of changes with continuing
15 education. So now they're holding this meeting, it
16 seems like every year, to kind of keep up with the
17 volume of things that need to happen.
18 So what I wanted to say about this is that
19 there many, many aspects of this that folks in the
20 community don't realize go on. There are, I forget,
21 seven or eight different states that approve
22 continuing education for radiology, rad tech in some
23 way, shape or form. There's several groups,
24 societies, CE-approving organizations, and of
25 course, there's ASRT, which has mountains and

1 mountains of CE and ARRT at the regulatory level
2 which has its requirements for what you need to do
3 to renew that license.
4 All of this, the goal of all of us is to not
5 have CE, the one organization that says is really
6 good and it's relevant to this matter and it's worth
7 this many hours of effort. And another organization
8 you go, oh, that's crap and it's worth nothing. You
9 know, it should not happen like that, right? We
10 should all be using the same standards and the same
11 -- so this, this mechanism, I think, pre-dated me in
12 this program and it is continued, and gotten more
13 complicated as time goes on. So we as the State of
14 Florida, appear, especially Kelly, the CE manager,
15 go to do a couple different things.
16 So there are changes coming and there are
17 changes that many of you are aware of. We've
18 modified CE requirements in Florida to become, as I
19 described it, more and more granular. We used to
20 not approve things that are less than a hour. Then
21 we didn't approve things less than a half an hour.
22 Then they want us to approve things 15 minutes long
23 in terms of length of time. Now with the rest of
24 this, it's becoming subject matter specific. So if
25 you were licensed by ARRT after January, July 2011,

1 whatever the date was, you're going to have to go
2 through this requalification. In addition to renew
3 your CE, you're going to have to start showing even
4 more specific subject matter for the particular kind
5 of license that you have.
6 That means that you have to actually have all
7 that granularity out in the approving of the course,
8 itself. It's not, oh, here's 16 hours worth of
9 training at this conference and it's all in
10 radiography.
11 I went to the whole meeting; I get 16 hours
12 worth of credit. It's not like that anymore. So
13 it's not really a battle, but where we're playing
14 catch up because we're states and we have
15 regulations and many other concerns, and ARRT, and
16 some of the other groups are way out there in front
17 changing things. And we're like, what? Why are we
18 doing that? Okay.
19 So this is why we're voicing our opinions on
20 how things are changing, how fast things are
21 changing and trying to maintain that, that
22 uniformity of, well, if it's approved here, it's
23 going to get the same type of subject matter review
24 and same number of hours for each of those by this
25 other organization, some other part of the country.

1 So your tax dollars at work. Actually ARRT's
2 because they pay for this to go out there and do the
3 meeting.
4 But I just want to make sure that you were
5 aware of that aspect of things.
6 Now, here's another one. The exam fees are
7 going up. Surprise. No, they're not going down.
8 Let's see here. So here's notification. So
9 effective January 1st, 2020, the current fees are on
10 the left. The fees on the right now, the way it
11 works with our regulations and in Florida, they --
12 the person who applies to MqA pays us a $50
13 application fee that goes to the State of Florida.
14 Once they're approved, we send their information to
15 the national registry, and they give them
16 information about how to register for the Prometric,
17 Pierson View, whatever it is these days, testing at
18 the test center and they have to pay this fee
19 directly to ARRT.
20 So the fees on the left are what's on our
21 website. Basically the basics, what they call
22 limited scope is what we call basics. So the basics
23 pay 125; everybody else pays 140. And effective
24 January 1st, the basics are going to be paying 140
25 and everybody else is going to pay $35 more for just

1 the ARRT examination fee. Got that? Okay.
2 KATHLEEN DROTAR, Ph.D.: For Florida. For
3 Florida licensing.
4 JAMES FUTCH: Yeah. I don't know, they're --
5 I'm assuming they're going to charge the same thing
6 to the other states through contractors.
7 KATHLEEN DROTAR, Ph.D.: Yeah. Ours is
8 applying directly with our students due to the ARRT,
9 it's a $200 fee. And they need to renew their
10 license by endorsement.
11 JAMES FUTCH: So on our website, we've had this
12 up for, I think a month or two. And this is the new
13 fees that you're seeing and there's a little
14 footnote. I won't show you, but there's a footnote
15 down at the bottom this says this is the fee
16 effective January 1st, 2020.
17 You might ask, well, are we going to, mental
18 note, 2020. It took a little bit of work to get
19 this up here. Not going to have them change it at
20 this point. I just wanted notice to be given out.
21 So there's notice on the website. There's
22 notice through your members, through your societies,
23 through your facilities. Everybody is aware now
24 that the fees are going up.
25 This, by the way, this is an interesting aspect

1 of the statute. The statute is written so that we
2 have regulatory control and authorization of what
3 they pay us. The fee to the national organization
4 for the testing is exempted from that. That's not
5 covered. And does anybody else know of any other
6 testing organization that might be providing all of
7 these different things to --
8 KATHLEEN DROTAR, Ph.D.: Instead of paying
9 ARRT? Is there such an animal?
10 JAMES FUTCH: The look on your face. Is there
11 another?
12 KATHLEEN DROTAR, Ph.D.: There is no other.
13 JAMES FUTCH: I know. I know that.
14 KATHLEEN DROTAR, Ph.D.: That was funny, James.
15 JAMES FUTCH: I was just saying that so it's in
16 the Record in case somebody up the chain of command
17 looks at it.
18 All right.
19 REBECCA McFADDEN: Has there been any change in
20 the application fee with the change in the national
21 registries?
22 JAMES FUTCH: I'm glad you mentioned that. No.
23 REBECCA McFADDEN: Why?
24 KATHLEEN DROTAR, Ph.D.: It was changed about
25 two --

1 JAMES FUTCH: We're at the caps for everything
2 regarding radiologic technology -- I wish Janet was
3 here -- for, what is it? 2019. I think twenty
4 years at least. We are not at the cap in one
5 particular area, which is the renewal fee to renew
6 your license.
7 REBECCA McFADDEN: Right.
8 JAMES FUTCH: It's currently 55 for the first
9 and 45 for the additional. The cap is 75. We just
10 did our annual regulatory plan, which we do every
11 year, which we tell the agency and everybody else,
12 this is the areas of the rules we think we will be
13 changing in the coming year or might need to change.
14 And in that lovely document, there are sections that
15 ask if we are covering our costs. Are we recovering
16 what it costs to do this. And we are not in that
17 one area.
18 We had a package -- help me with this. We had
19 a package during the Crist administration, that --
20 and this council saw it, which would basically have
21 increased the fees to the cap for renewal. So
22 instead of paying 55 for one license, you pay 75.
23 Most people when they look at that as licensed
24 professionals go, wow, that's a great deal. Even at
25 the higher level.

1 KATHLEEN DROTAR, Ph.D.: I know. And the
2 advisory council at the time said that it was one --
3 it was still one of the least expensive licenses in
4 the U.S.
5 JAMES FUTCH: Right. So that one was published
6 as a proposed rule making. We received no
7 adversarial comments.
8 In the process under Chapter 120, after all
9 that, those two time periods expire, is you go back
10 up through the agency and you get a sign off by the
11 agency head and then it's posted as final and that's
12 where it failed. I'm sorry. At that particular
13 step.
14 And I had a very nice, personal conversation
15 with people who are no longer with the agency, who
16 said, after my 15-minute explanation of why we were
17 doing this, that that is the most reasoned,
18 well-evidenced, documented argument I've heard in a
19 long time. You'd make a excellent case. However,
20 we're not going to do rule changes this year, so we
21 didn't. And for many years afterwards.
22 So it could be something that could be raised
23 again and --
24 REBECCA McFADDEN: Would that raising provide
25 any additional assistance for the office of

1 radiation control and all these different entities
2 that we house? Would that provide any -- I mean,
3 looking at the number of licensures that are out
4 there, the impact is going to be, would it be
5 minimal or -- like, if you raise the fees, you have
6 X number of dollars within the budget brought in.
7 JAMES FUTCH: There is -- I don't have the
8 numbers in my head right now as to how much of the
9 shortfall it would cover. I can't --
10 REBECCA McFADDEN: Maybe an additional position
11 that you need.
12 JAMES FUTCH: Yeah.
13 KATHLEEN DROTAR, Ph.D.: Especially for MqA to
14 help with all the licensing.
15 JAMES FUTCH: Yeah. Well, it's something to
16 take under advisement anyway. I don't know. Would
17 the current council be opposed or in favor?
18 REBECCA McFADDEN: I would be in favor of an
19 increase to provide additional resources from the
20 State level, yeah.
21 KATHLEEN DROTAR, Ph.D.: As a person with three
22 licenses, I have no objection.
23 REBECCA McFADDEN: She's getting paid very well
24 with this through licenses. It's okay. Let it go
25 up.

1 KATHLEEN DROTAR, Ph.D.: I wish.
2 RANDY SCHENKMAN, CHAIRPERSON: I think probably
3 we all feel that if the money would be going to --
4 REBECCA McFADDEN: If it would go --
5 RANDY SCHENKMAN, CHAIRPERSON: -- to proper and
6 good use, then we would not object.
7 KATHLEEN DROTAR, Ph.D.: Yeah.
8 REBECCA McFADDEN: Yeah. I agree, Randy.
9 JAMES FUTCH: We'll take that under advisement.
10 Appreciate that.
11 Okay. So that was the fee increases. Let's
12 see, what's next? I have ten minutes. Okay. We
13 have a laser document that needs some minor tweaks.
14 We have -- we're going to make a -- redouble our
15 efforts try and get that --
16 BRENDA ANDREWS: With a new person.
17 JAMES FUTCH: -- with a new lawyer, the new
18 general counsel's office. It's fairly simple when
19 we modified this laser requirement last time, the
20 numerical titles of the different sections, you
21 know, laser light shows, administrative controls,
22 engineering controls, et cetera, surveys, the kind
23 of stuff that you expect from any radiation related,
24 the titles were left out of the actual section. So
25 all it has is numbers for the different sections.

1 So if you're reading through it, you actually
2 have to read this massive amount of text to figure
3 out what that section pertains to. It also doesn't
4 have a table of contents. I have created one
5 external to the rule process. If you go to my
6 website, DOH website, and pull down the laser
7 document, you'll get a document that has a table of
8 contents. But in the actual incorporated rule on
9 the Department of State's website, it has no table
10 of contents nor titles for the sections. And
11 probably by now -- have we updated the 036 again
12 since 2018?
13 ADAM WEAVER: I think you're going to have to
14 look at the classifications, too.
15 JAMES FUTCH: Probably. All right. So we're
16 moving forward to try and get that.
17 These two areas --
18 ADAM WEAVER: You better hurry up because
19 there's another draft here or one coming out soon.
20 JAMES FUTCH: Oh, really?
21 ADAM WEAVER: Yeah. Hopefully we'll know more
22 about that next week.
23 JAMES FUTCH: So we're not going to talk too
24 much about the RA section right now. The
25 radiologist assistant, we had a whole presentation

1 about it last time with Christen. I've looked at
2 the documents now and here's the short and the
3 skinny.
4 We're -- our statute requires that we have a
5 practice standard, if you will, for the RA, which is
6 based upon the consensus agreement of ACR, ASRT and
7 ARRT with the level of supervisions required for
8 those procedures.
9 When this whole thing was coming together in
10 2005, those three organizations had agreement on a
11 role delineation, which actually has one of the most
12 specific practice standards I've ever seen by
13 individual procedure with individual levels of
14 personal, general or direct supervision required by
15 the supervising radiologist.
16 What they have now is not that quite. What
17 they have now, ARRT as of 2018, has an entry-level
18 clinical activities, which actually tracts almost
19 exactly the old document, but has no levels of
20 supervision per procedure. It just kind of says
21 look, if you're an entry-level RA, everything is
22 direct. All the places if we adopted that, all the
23 places where it says personal, those are gone, which
24 probably maybe somewhat is desired. All of the
25 general is gone and now it's also direct. And it's

1 also only for entry-level folks. So I don't really
2 know what you do once you've been working in the
3 profession for a while.
4 There is a practice standard. There are two
5 protibations with the practice standard. It also
6 doesn't specify levels of supervision in any kind of
7 granular fashion. And since we last adopted
8 practice standards for radiographers, nuclear med
9 techs and all the different subcategories of
10 technologies, ASRT has put them all into one
11 document instead of separate documents for each
12 profession.
13 KATHLEEN DROTAR, Ph.D.: No.
14 JAMES FUTCH: So reading through this -- this
15 is just my two cents -- take it for what it is or if
16 you care for what I think, but once you read through
17 that document, it's footnote here, footnote here
18 does not apply to this profession or applies to this
19 profession because they're trying to group all the
20 different things into like a standard area.
21 So if your standard is patient care, there
22 is -- here's what the radiation therapists and
23 nuclear med tech, what applies in this area; here's
24 what doesn't apply, and then it gets even more
25 specific when you get to the actual nuts and bolts

1 of the profession.
2 This is my long and short way of saying, I'm
3 not really sure how to -- which of these documents
4 to grab to put together to call this the replacement
5 document. So it's going to take more thought,
6 perhaps another shot with the committee, with an RA
7 in place, saying is this close to what we think is
8 what we want?
9 KATHLEEN DROTAR, Ph.D.: ARRT is just going to
10 do the entry level because that's what the
11 certification is for. However, I think I saw
12 something that was advanced practice on the website
13 for -- and I didn't read it, so I don't know what it
14 is. But it was different and that might be
15 addressing some of that. And at the House of
16 Delegates in June, we did vote on the changing the
17 practice standards because there was something like
18 800 and some pages when you put them altogether, so
19 they were taking the common denominators, putting
20 those together and then they will have --
21 JAMES FUTCH: Up in the front.
22 KATHLEEN DROTAR, Ph.D.: -- for each individual
23 discipline, a separate section specific to them. So
24 that's -- they're working on that this year, because
25 they got it down to, I think 80 pages as opposed to

1 the 800.
2 JAMES FUTCH: To think everything being in the
3 same document is somewhat problematic because we
4 also just adopted the 2017 versions as separate
5 documents in the rule. And it makes me a little
6 queasy to have one document and to point -- because
7 we point people to these practice standards all the
8 time. Somebody calls up, they've got a question
9 about this, that and the other thing, it's radiation
10 therapy, go see this practice standard, it's
11 incorporated here. And they can go look at it. We
12 essentially now, we're pointing them to a document
13 that has everything in it. From therapy, to nuclear
14 medicine, to diagnostic imaging at the different
15 levels of responsibility.
16 It's one thing to adopt a practice standard
17 from a national association by reference in your
18 regulation when it's at least just that profession's
19 document that you're referring to in the regulation.
20 When you're referring to a document, you're going to
21 have to say, well, you know, not the whole thing.
22 Not pages, you know, 16 and 23, 44. Just the ones
23 that say RA. Well, it's not even all in one section
24 because it's spread throughout the document. It's
25 going to be a nightmare trying to do that.

1 There's one place in the PET standard when we
2 allowed the nuclear medicine technologists from
3 NOTCB with a CT certification to be granted the CT
4 certificate up in Florida. In the PET section,
5 which is .003, that one is written for nuclear med
6 techs who don't have any CT certification and that
7 one requires some additional 16 hours of training.
8 It exempts people who have CT already, but it
9 doesn't exempt the NOTCB CT because we forgot to do
10 that part. So we've to do some clean up in that
11 section.
12 I've got to plug this. I know it's three
13 minutes 'til. Adam and I had this. HPS meeting
14 next week, I finally, after literally years of
15 trying to get this happen, we had this idea. I'm
16 part of another group, a body that publishes the RF
17 safety standards, that all your cell phones, FCC to
18 protect you from RF exposure, et cetera, et cetera,
19 et cetera.
20 One of my co-chairs, one of the committees,
21 Kevin Graph, we were talking at some of the previous
22 meetings about what really drives this issue.
23 Because this issue is not really driven by some sort
24 of earth-shattering science that says, oh, my
25 goodness, all the cell phones are going to cause

1 cancer and we're all going to die; this kind of
2 stuff. It's like miniscule, minor protibations in,
3 you know, cutting-edge research that when you try
4 and reproduce the stuff that's supposedly showed
5 some kind of effect, you can't really reproduce it
6 many times, so it's down in the noise.
7 And what happens is, people get driven by what
8 the news media writes about what people, who they
9 view as their professionals to take counsel from,
10 their doctors and the other folks, industrial
11 hygienists, health physicists, those that happen to
12 know one. And none of those folks really have --
13 this is not your day-to-day, you know, thing. We're
14 dealing with ionizing and NCRP and NCRCPD
15 regulations and FDA and the rest of it.
16 So this is the talk we came up with to explain
17 to scientific and engineering professionals, medical
18 professionals eventually, if this works out well, to
19 try to bring it to the Florida Medical Association
20 and Florida Nurses Association. Who knows. But
21 it's, how do you understand what is a good study?
22 So this is supposed to talk about historical
23 results, you know. What are the hallmarks in this
24 field. What kinds of studies. What makes something
25 good health effects research in the electromagnetic

1 fields. So that's what this is about.
2 And Kevin, who was going to give the talk,
3 called me a week and a half ago and said he'd taken
4 a job with FCC. So he's not going to be there
5 unless they worked out the relationships because the
6 FCC is really hinky to have people go out and talk
7 about stuff like this. I mean, like no agency I've
8 never seen before.
9 So his health effects, epidemiology person,
10 Dr. Pamela Dopart, is going to be giving this
11 particular talk at the meeting.
12 I should show the rest of it, shouldn't I?
13 Emphasis is placed on the strengths and weaknesses
14 of key historical studies and ancient research.
15 This is the abstract. This may have changed by the
16 time we get to the actual talk. This is what we
17 started with and what we presented to HPS, which
18 they accepted.
19 By the way, this is being offered in the
20 morning session, because the industrial hygiene
21 president thought it was a great idea, too.
22 ADAM WEAVER: Yeah, yeah. It fits them, too.
23 They get the same questions, I would assume.
24 JAMES FUTCH: Yeah, it's beautiful. Then the
25 last thing, the national safety standard was

1 published last Friday. HPS is about to send out an
2 announcement to its members, which I can find some
3 place.
4 ADAM WEAVER: Get it for free?
5 JAMES FUTCH: There it is. HPS' second
6 point -- actually, it just released C95 --
7 incorporates the full spectrum. We're going all the
8 way from essentially no fields, no, you know, zero
9 hertz DC all the way up to 300 gig. And I actually
10 happen to have a copy of it, which I can find, which
11 I would very much love to show you. There it is.
12 There's what the standard looks like.
13 By the way, these are available free of charge
14 thanks to a generous donation from the U.S. military
15 which, we built the standard for them a couple years
16 back so they could use it, so all the NATO countries
17 can use it when they're in different ports in Europe
18 and around the world which may have competing
19 standards and, hey, you can't use that radar system.
20 Yeah, you can, it's okay. So the U.S. military has
21 been funding the development of some of these. And
22 this one, let's see. There you go.
23 I'm going to shamelessly plug this because this
24 is the first time I ever gotten my name into one of
25 these things.

1 (Laughter)
2 JAMES FUTCH: Finally.
3 (Applause)
4 MARK SEDDON: Good job.
5 JAMES FUTCH: I'm done.
6 ADAM WEAVER: Good way to leave it.
7 (Laughter)
8 JAMES FUTCH: I remember when Debbie Gilley did
9 this with NCRP 161.
10 RANDY SCHENKMAN, CHAIRPERSON: Okay. So old
11 business. Anybody have anything for old business?
12 (No Response)
13 RANDY SCHENKMAN, CHAIRPERSON: No?
14 KATHLEEN DROTAR, Ph.D.: No.
15 RANDY SCHENKMAN, CHAIRPERSON: Okay. Onward
16 ho. Administrative update. Brenda.
17 BRENDA ANDREWS: Okay. In your packets, I
18 included a copy of the updated roster for the
19 council members. And we talked, last time we met,
20 about those who are coming up for term end, ending,
21 October 27th. And right now, we have submitted
22 letters --
23 (Member sneezing)
24 BRENDA ANDREWS: Bless you. Are you allergic
25 to me talking?

1 (Member sneezing)
2 (Laughter)
3 BRENDA ANDREWS: All right. Right now, we have
4 the podiatric, the certified podiatric position
5 that's vacant right now that Stratis was the member
6 for that position. And we have a nominee for that
7 position whose name we have put forth. Some of the
8 council members may know him from when he served on
9 the council before. He ended his term in 2012, I
10 believe it was. His name was Albert Armstrong. He
11 has shown a desire to come back to the committee and
12 was nominated for that by the society. So his name
13 has been put forth in our appointment package that
14 we've submitted.
15 We also have two other names of current council
16 members who wish to renew. And we have gotten the
17 society letters back on them and we put their names
18 forth as well. And that would be Mark, I've got
19 your name in the pot. And Mark, the other Mark,
20 Mark Wroblewski is in the pot.
21 We will have a second round, which would
22 include certified health physicists, an expert in
23 environmental matters and then Christen Crane-Amores'
24 position, the certified radiologist assistant, as
25 James mentioned earlier, with her new endeavors and

1 her new family situation, she's got a lot on her
2 plate. So she has opted not to seek reappointment
3 after October 27. So we are looking forward to
4 getting a nominee for that position as well. We've
5 gotten some applications on it, but not a letter
6 from a society yet.
7 So once we get all that and get it vetted, we
8 will be sending through the second group, second and
9 final group for the last three people. So until
10 then, as we get those nominations, we will notify
11 you and let you know if your name came up as the
12 chosen person for reappointment.
13 And let's see. Anything else you wanted to say
14 about the appointments? That's it. So that's where
15 we are with that. Any questions on what's happening
16 with our vacancies?
17 (No Response)
18 BRENDA ANDREWS: I guess the next thing is to
19 decide on when we're going to meet again. In your
20 packet, I have two calendars, April and May. So you
21 want to talk about that?
22 RANDY SCHENKMAN, CHAIRPERSON: May would be
23 better for me. I don't know about anybody else.
24 BRENDA ANDREWS: Okay. Everybody good in May?
25 Okay.

1 KATHLEEN DROTAR, Ph.D.: Just not the first
2 week.
3 BRENDA ANDREWS: Not the first week. Okay.
4 Okay. So we've got the 12th, 19th and the 26th.
5 CLARK ELDREDGE: CRCPD, when is that?
6 CYNTHIA BECKER: May 4th through the 7th.
7 BRENDA ANDREWS: Okay. That's that same week.
8 Anybody want the second week? Is that --
9 CYNTHIA BECKER: May 12.
10 BRENDA ANDREWS: May 12. Anything going on
11 that week for anybody?
12 REBECCA McFADDEN: I'm trying to figure out
13 what's going on tomorrow.
14 KATHLEEN DROTAR, Ph.D.: Sounds okay.
15 BRENDA ANDREWS: What's that?
16 REBECCA McFADDEN: I'm trying to figure out
17 what's going on tomorrow.
18 (Laughter)
19 BRENDA ANDREWS: Well, we have time.
20 MARK SEDDON: The 12th is good.
21 REBECCA McFADDEN: 12th works.
22 BRENDA ANDREWS: Okay. Let me say this: The
23 other thing is, we like to make sure we get our bid
24 in for the meeting space because when I did it
25 before, I was pretty sure we were way ahead of time

1 to get the Hampton Inn again with their nice
2 windows, and it was already booked.
3 ADAM WEAVER: Really?
4 BRENDA ANDREWS: Yeah. So it turned out fine.
5 We got another nice room, but people are booking
6 these rooms up really fast. So the better -- the
7 sooner we get it in, the better.
8 Now, if there's going to be a problem with us
9 getting either one of the rooms down here at this
10 complex, I'll let everybody know so we can perhaps
11 choose another date and I'll get them to give me
12 some other dates. Whether the 19th or the 26th
13 might be available, if that's the date.
14 CLARK ELDREDGE: The 26th would be --
15 BRENDA ANDREWS: That's Memorial Day.
16 CLARK ELDREDGE: Yeah. The 25th would be.
17 BRENDA ANDREWS: So the 25th is a holiday.
18 NICHOLAS PLAXTON: Probably use the 19th as a
19 back up.
20 BRENDA ANDREWS: What's that?
21 NICHOLAS PLAXTON: Use the 19th as a back up if
22 you can't get the 12th.
23 BRENDA ANDREWS: Okay. All right. I'll check
24 on that pretty much when I leave here because I
25 don't want us to lose a place down here. This is a

1 really nice complex.
2 NICHOLAS PLAXTON: It is.
3 BRENDA ANDREWS: Very convenient for everybody.
4 Okay. That's me.
5 RANDY SCHENKMAN, CHAIRPERSON: Okay. Well,
6 anybody have anything else that they want to talk
7 about or comment on?
8 (No Response)
9 RANDY SCHENKMAN, CHAIRPERSON: And then I guess
10 we are adjourned.
11 REBECCA McFADDEN: Thank you.
12 (Proceedings concluded at 3:12 p.m.)
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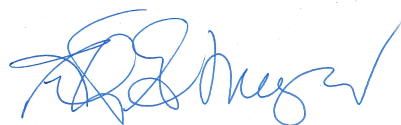
1 CERTIFICATE OF REPORTER
2 STATE OF FLORIDA:
3 COUNTY OF HILLSBOROUGH:
4
5 I, RITA G. MEYER, RDR, CRR, CRC, do hereby certify
6 that I was authorized to and did stenographically report
7 the foregoing proceedings and that the foregoing
8 transcript is a true and correct record of my
9 stenographic notes.
10 I FURTHER CERTIFY that I am not a relative,
11 employee, attorney or counsel of any of the parties, nor
12 am I a relative or employee of any of the parties,
13 attorneys or counsel connected with the action, nor am I
14 financially interested in the outcome of the action.
15
DATED this 23rd day of October, 2019.
16
17



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