News & Views

Citizen Advocacy Center

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ACCESS TO CARE

Illinois Pharmacies Must Post Notice of Right to Contraceptives

Editorial Note: An August 8, 2006, press release announced that Gov. Blagojevich's contraceptives rights rule won approval from legislative rules committee. Under the rule, pharmacies will be required to display signs informing women of their right to get contraceptive prescriptions filled without delay, and how to file complaints when their rights are violated. (See CANews Vol. 17, No. 3, p. 11) The press release follows:

The Joint Committee on Administrative Rules (JCAR) today voted to adopt Governor Rod R. Blagojevich's proposed rule that ensures women know their rights to have access to contraceptives. The new rule requires Illinois pharmacies to post signs outlining consumers' right to obtain contraceptives, and providing information on where to file a complaint with the state if a pharmacy violates that right. Governor Blagojevich introduced the rule to prevent pharmacists from trying to circumvent an emergency rule he filed in April 2005. That rule requires them to fill all FDA-approved birth control prescriptions in a timely manner if the drugs are in stock and a legal prescription has been presented.

"Women will now be armed with the information they need to make sure that pharmacies are respecting their right to get the medication their doctors prescribe for them. Any pharmacist who might still think they can deny women access to birth control can expect to be reported to the state and penalized," said Gov. Blagojevich. "As we said when we began this battle, filling prescriptions for birth control is about protecting a woman's basic right to healthcare. Nothing more. Nothing less."

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The signs will remind customers what their rights are if the drugs requested are not in stock, and provide them a website, (http://www.contraceptives.illinois.gov) and toll-free telephone number (800-280-4149) where they can file a complaint with the Department of Financial and Professional Regulation (IDFPR), which regulates pharmacies.

The Governor proposed the sign requirement earlier this year after a health care provider in the West Peoria area attempting to call in a prescription for emergency contraception was told that the drug was not in stock. The next day, the provider called back and spoke to the pharmacy manager who affirmed that they carried the drug, and had had it in stock the day of the original call. Under the Governor's emergency rule, pharmacies that stock contraceptives are required to fill prescriptions without delay.

The pharmacy sign rule will take effect immediately upon being filed in the Illinois Register. Stores will be expected to have signs posted by early September. The signs will be required to be clearly printed on stock of at least 8 ½ X 11 inches and posted near the intake counter of each licensed Illinois pharmacy.

"Too many women have been forced to seek alternative sources for their birth control prescriptions. It's important that pharmacy customers understand their rights and know that those rights will be protected," said Dean Martinez, Secretary, IDFPR

The sign says:

> **If this pharmacy dispenses prescription contraceptives, then you have the following rights under Illinois law:**
>
> **The pharmacy must dispense your prescribed contraceptives without delay. When your contraceptive is out of stock, you have the following options: the pharmacy must cooperate with your doctor to determine a suitable alternative, order the contraceptive, or transfer the prescription to another pharmacy of your choice.**
>
> **You can instruct the pharmacy to return the prescription to you at any time.**
>
> **If you have questions about your rights or wish to file a complaint, please call the Illinois Department of Financial and Professional Regulation at 800-280-4149 or visit *http://www.contraceptives.illinois.gov.***

Washington State Governor Pressures Pharmacy Board on Proposed Rule

At its June 1, 2006 meeting, the Washington State Board of Pharmacy proposed changes to its statute's section on "Pharmacist's professional responsibilities." The proposed new language would permit pharmacists to decide not to dispense a prescription:

> Pharmacists and pharmacy ancillary personnel shall not obstruct a patient in obtaining a lawfully prescribed drug or device. If a pharmacist cannot dispense a lawfully prescribed drug or device, then the pharmacist must provide timely alternatives for the patient to obtain treatment. These alternatives may include, but are not limited to:
>
> - Referring the patient or patient's agent to another on-site pharmacist.
> - If requested by patient or their agents, transfer the prescription to a pharmacy of the patient's choice.
> - Providing the medication at another time consistent with the normal timeframe for the prescription.
> - Consulting with the prescriber to provide an alternative medication therapy.
> - Return unfilled lawful prescriptions to the patient or agent; or
> - Provide to patient or agent a timely alternative for appropriate therapy.
>
> Nothing in this rule shall interfere with a pharmacist's screening for potential drug therapy problems, pursuant to the pharmacist's professional responsibilities.
>
> Nothing in this rule requires pharmacists to dispense a drug or device without payment of their usual and customary or contracted charge.

Washington Governor, Christine Gregoire reacted negatively to this proposed rule change because it apparently opens the door to pharmacists refusing to fill prescriptions for religious reasons. She announced at a June 5, 2006 press conference that she would explore all legal options to change the proposed amendment. She told the press gathering that her options ranged from proposing her own substitute rule to replacing the members of the pharmacy board if they do not modify their proposal.

The pharmacy board revisited the proposed language at its July meeting and posted the following notice on its Web site:

> **On July 20, 2006, the Board of Pharmacy voted to further discuss the proposed rule language regarding a pharmacist's responsibilities in dispensing lawful prescriptions at its August 31 meeting and asked staff not to file with the Code Reviser's office.**

ADMINISTRATION

Federation of State Boards of Physical Therapy Recommends Customer-Friendly Policies

Editorial Note: The Summer issue (Vol. 21, No. 2) of the Federation of State Boards of Physical Therapy's federation forum contains the following article entitled, Using Communications to Enhance Public Protection. In our view, the recommendations in this article are relevant to all professional licensing boards.

Using Communications to Enhance Public Protection, by J. Kent Culley, Esq., FSBPT Counsel for Legislative and Regulatory Affairs

In this article, we will discuss ways that licensing boards, in order to enhance protection of the consumer, can interact or communicate with consumers, licensees, legislators or even professional associations regarding board issues of activities.

Consumer advocacy is no longer optional for regulatory boards. It has become one of the focal points of *The Model Practice Act for Physical Therapy*, particularly in the current 4th Edition. Section 4.12 of the Model Practice Act specifically focuses on the topic *Rights of Consumers*. The following are several examples of activities taken by jurisdictions to increase general knowledge of their role and responsibilities in protecting the consumer of physical therapy services.

A licensing board's public website provides key information regarding the make up of the member board, its local and how they may be contacted for information or for filing complaints. The website is available to anyone with a connection to the Internet.

An issues forum is held twice a year to discuss new or proposed regulations or other policy issues. These forums are held primarily to benefit licensees of the profession. They are supplemented by articles regarding state board activities and matters of interest that then appear in the professional association's regular newsletter to its members.

Representatives of the state board testify before legislative or administrative bodies regarding regulations, law or general healthcare issues.

The licensing board has designated a liaison with the legislative branch to facilitate communications regarding regulation and licensing issues. The liaison, together with representatives of the board, updates appropriate legislators or committees on board activities and issues.

Many licensing boards provide newsletters to licensees at least annually. The newsletter includes changes or proposed changes in the regulation. It may also discuss board policies and procedures and issues brought to the board that would be of interest to licensees. The newsletter may include a hypothetical practice scenario and provide analysis, questions and board-recommended answers to such practice scenarios and an attempt to clarify practice issues raised by licensees or the public.

Most state boards provide links to their licensure and disciplinary database on their websites. Consumers can immediately access licensure information plus any disciplinary action against a licensee by inputting information about the licensee into the database. The FSBPT website now provides links to individual jurisdictions' licensure information on its public website (http://www.fsbpt.org) under the tab,

"Licensing Authorities." Other information that licensees, consumers and the public can find on boards' websites includes information on licensure renewal, disciplinary measures, laws and regulations and the correct way to file a complaint.

Training sessions for the public members on its board (who represent the consumer) as well as its new members are provided relating to law, regulations and board procedure.

Board meetings are moved from place to place around the state. Since the meetings are public, it gives licensees as well as consumers the opportunity to attend meetings, observe the operation of the state board and hear the issues being discussed.

Brochures are produced which include subjects such as consumer rights, licensing information and how to contact the licensing agency regarding questions or complaints.

There are many more methods for state licensing boards or agencies to communicate or interact with consumers, licensees, and other public sectors than we have listed here. The important point is that licensing boards should be easily accessible to consumers, licensees, and other public sectors. In the past, licensing boards have been the target of many who would claim they are just the "gatekeepers" to limit access to a particular profession. (See various Pew studies.)

Granted, not all 53 jurisdictions have an independent licensing board that may operate with its own budget including communications with licensees and the public sector. Some licensing agencies operate under an umbrella board or under medical or health related boards and have to depend on the whim of those boards relating to spending money or creating programs that are designed to provide valuable information about the licensing agency particularly to the consumers of physical therapy services.

It should be noted that, in one jurisdiction where funding to the boards was handled on the state level, which in the view of the various licensing boards was inadequate to meet their role in protecting the public, the boards came together to take action to resolve this dilemma. The result was the enactment of a law that required each board to be financially self-sustaining through its fees and charges that went directly to that board instead of the General Funds, which previously utilized the boards' fees and changes in the overall state finances.

Nevertheless, the role licensing boards serve in protecting the public should be strongly promoted by whatever means and made clear to the public. The Federation, for example, could become the repository of ideas and methods of communicating information to the public, licensees and other sectors from all of its members to enhance the exchange of ideas. However this is expedited, it is a must that the rules, policies and operations of licensing boards become as transparent as possible to all sectors of the public to maintain and enhance the licensing boards' or agencies' credibility and effectiveness.

LICENSURE

National Conference of Commissioners on Uniform State Laws Approves Emergency Volunteer Healthcare Practitioners Act

On July 13, 2006, the National Conference of Commissioners on Uniform State Laws (NCCUSL) announced the completion of work on an Emergency Volunteer Healthcare Practitioners Act. The act was drafted in response to hurricane Katrina and other recent natural disasters and will allow state governments to give reciprocity to other state's licensees on emergency services providers so that covered individuals may provide services without meeting the disaster state's licensing requirements. The Uniform Emergency Volunteer Healthcare Practitioners will be submitted to the states for their consideration and adoption.

According to NCCUSL President, Howard J. Swibel:

> **The problem of allowing qualified healthcare practitioners to assist in other states in the event of an emergency is so urgent that the National Conference acted with unprecedented speed to complete this new uniform act. The drafting committee began its work only in February, but with input and consultation from dozens of groups around the country, the first stage of its work was completed in its first year of consideration. We are hoping that passage of this act in the states will save untold numbers of lives if this country was ever faced with another catastrophic disaster.**

After last summer's devastating Gulf area hurricanes, many qualified physicians, nurses and other medical professionals from other states faced confusing administrative hurdles in obtaining permission to practice in the affected areas that delayed and impeded the timely delivery of essential health care services. Although laws exist to provide for the interstate recognition of licenses issued to "federalized" health-care professionals and to state and local employees, no uniform and readily understood system exists to recognize licenses issued to other health-care professionals deployed from one state to another during these disasters.

Approximately 20 states have enacted laws providing for the interstate recognition of licenses held health-care professionals responding to emergencies, including professionals associated with voluntary organizations such as the American Red Cross. But qualifying for interstate license recognition differs substantially from state to state and this lack of a uniform system impeded the ability of healthcare professionals to respond to the crisis created by Katrina and Rita.

The new uniform act includes specific statutory guidelines on the following: language making it clear when provisions of the act take effect, such as during officially-declared states of emergency; requirements for a volunteer healthcare practitioner registration system; language restricting its application to medical professionals holding a valid and current license in another state who are not subject to disciplinary proceedings. Sections dealing with liability, immunity, and workmen's compensation have been reserved for further study during the 2007 annual meeting of NCCUSL.

Boards of Nursing Evaluate Six Years of Licensure Compact

The National Council of State Boards of Nursing (NCSBN) contracted with The Gallup Organization and Insight Policy Research to interview nursing board executive directors and poll practicing nurses to ascertain their perceptions, experiences, and attitudes toward the Nurse Licensure Compact (NLC). The NLC began Jan 1, 2000 when five states enacted laws to recognize each other's Registered Nurses, Licensed Practical Nurses, and Licensed Vocational Nurses. Nurses in NLC states hold a single license that makes them eligible to practice in the licensing state as well as other states participating in the NLC, subject to each state's practice acts and regulations.

Board administrators in NLC states pointed out several positive consequences of being in the compact – for the state boards as well as practicing nurses, especially those who want to be traveling nurses or to practice telemedicine. NLC gives these and other nurses reduced fees and greater flexibility when they practice across state lines.

The administrators cited benefits to state boards of nursing include improved communication and collaboration with other NLC states, streamlined licensure procedures and fewer unnecessary regulatory barriers. Benefits to employers include an easier hiring process.

The major challenges cited by NLC board administrators include educating affected parties about NLC, updating forms and databases to coincide with new NLC requirements, and establishing consistent practice standards, particularly regarding discipline.

Administrators from states that have not yet signed on to the NLC, raised concerns about the possibility of lost revenue, the impact on the disciplinary process, inconsistent standards across state lines, difficulty with tracking nurses working in the state, adapting NLC legislation to accommodate different states' legislative context.

Surveys of practicing nurses revealed a high degree of awareness of NLC and overwhelming support for their state becoming part of NLC. Among the benefits nurses see in NLC include improved access to nurses in national emergencies and increased nurse mobility between states and between jobs. Most do not believe that the NLC lowers nursing standards.

IMPAIRED PRACTITIONERS

Social Work Regulators Compare Approaches to Impaired Practitioners

The Association of Social Work Boards' spring 2006 meeting included a panel presentation on dealing with impaired professionals. Regulators from Massachusetts, Michigan, Oregon and Quebec compared their approaches to treatment and discipline.

The Massachusetts Board of Registration of Social Workers does not have a formal program for impaired practitioners. One reason is lack of resources. In addition, the Board believes that the wellbeing of practitioners is the responsibility of the professional association. Only when there has been no clear violation of the practice act, the Board refers practitioners with chemical dependency issues to the Social Work Assistance Network (SWAN) run by the state chapter of the National Association of Social Workers. The Board can meet with a licensee against whom a complaint or self-report has been filed and has the power to open, investigate and prosecute cases.

Available sanctions range from reprimand to revocation. All decisions related to allegations of impaired practice are on the public record.

In Michigan, the social work board works with the Michigan Health Professional Recovery Program which monitors impaired practitioners in a confidential environment, unless there is a "destructive" relapse or other disciplinary issue, in which case the matter is reported to the Board and becomes public. Social workers are subject to a mandatory reporting requirement. The benefits of the program include early intervention and saving careers. A drawback is that the program is expensive.

Quebec has a relatively new comprehensive program for all impaired professionals, which does not yet include any social workers. The authorities have the power to require a medical examination for new applicants or anyone with a license when there is a suspicion of physical or mental problems that could lead to unsafe practice. Three physicians participate in the exam, one chosen by the board, one by the practitioner and a third chosen by the first two. The board has the power to restrict or prohibit practice if the doctors detect an "incompatibility" with practice.

The Oregon board operates an Impaired Professional Committee (IMP) that offers a voluntary, confidential alternative to discipline. Its philosophy favors rehabilitation according to a case-by-case approach. The board enters into contracts with impaired professionals, which may include practice imitations, 12-step programs, and drug screens. A practitioner who leaves the program without completing it must surrender his or her license. If a professional is noncompliant with the terms of the program, the case is transferred to the disciplinary track and becomes public information.

Editorial Note: The impairment program descriptions are based on an article in the June 2006 issue of the Association of Social Work Boards' association news.

DISCIPLINE

Florida Medical Board Called Lax on Discipline

Articles appearing on July 29, 2006 in the ***Palm Beach Post*** and Fort Lauderdale ***Sun-Sentinel*** took aim at the Florida Board of Medicine for being both slow and lenient in its discipline. Staff writer Phil Galewitz of the ***Palm Beach Post*** wrote about two cases in which the medical board waited years before disciplining physicians accused on patient harm. In one case, the board failed to take serious disciplinary action for several years against plastic surgeon Mark Schreiber despite investigatory findings implicating him in two patient deaths. The board put Schreiber on a year's probation in 1999 after a patient died following a nine-hour surgery. In January 2003, investigators concluded that Schreiber failed to ensure appropriate post-operative care after a procedure performed in his office, resulting in his patient's death. Schreiber has been sued eight times in 12 years, resulting in a total of $1 million in insurance payouts.

Nevertheless, as of the time the article was published, the board had not taken disciplinary action related to the case. (A check of the board Web site shows that an emergency suspension order was issued in August 2006.) In the second reported case against surgeon Paul Liebman whose patient

died after varicose vein surgery, it took the board nearly three years to find a physician willing to testify against the accused doctor.

The ***Sun-Sentinel*** article by health writer, Bob Lamendola, reported that after a year of study, the medical board decided against stricter penalties for surgeons who operate on the wrong body part or wrong patient, opting instead to promote systemic efforts, such as "time-outs" prior to surgery for a final check, to prevent these errors from occurring in the first place.

The context for this decision is an increase in the number of wrong-site surgeries – the board disciplined 45 surgeons for wrong-site surgery this year compared to 33 the previous year. Most of the 45 were fined from $5,000 to $15,000, issued a warning letter, and required to perform community service. Three had their licenses suspended temporarily and were fined $20,000. The new guidelines lower the minimum fine for first offenses from $10,000 to $1,000 and call for an automatic suspension after three offenses.

Texas Medical Board Praised for Diligence

In contrast to the previous article, the Texas Medical Board received very positive coverage in a July 10, 2006 article entitled, "Doctors Face Texas Medical Board's Watchful Eye," in the Houston Business Journal. Reporter J. Chris Roselius writes that investigations increased from 1,775 in 2003 to 2,131 in 2005. Medical board staff attribute the increase to legislation enacted in 2003, which gave the boards more enforcement funding by raising licensure renewal fees by $80.00. Increased funding enabled the board to hire more investigators, which enabled them to investigate more complaints and identify more violations of the standard of care. The board investigates about 12,000 complaints per year.

Board executive, Donald Patrick, told the ***Business Journal*** that many doctors mistakenly believe the board's purpose is to protect doctors. "We want accountability," he said. "A lot of physicians grew up without much accountability, but now I think we have their attention."

Medical Boards Adopt Guidelines for Addressing Sexual Boundary Cases

***Editorial Note: The Federation of State Medical Boards adopted sexual boundary guidelines at its April 2006 annual meeting. While these guidelines were designed and adopted by medical boards, we recommend that other professional boards review and evaluate these guidelines in comparison to their own. Making sure licensees observe appropriate sexual boundaries is – or should be – a major responsibility for all health care professional boards. The complete FSMB guideline can be found at* http://www.fsmb.org.**

The Federation of State Medical Boards' (FSMB) newly adopted guidelines for medical boards on addressing sexual boundaries defines physician sexual misconduct and provides recommendations to assist medical boards with conducting investigations, holding formal hearings, and choosing a disciplinary response, which may include physician monitoring and education.

The guidelines identify a variety of behaviors, gestures or expressions that constitute sexual impropriety, such as neglecting proper disrobing and draping practices or performing an intimate examination without clinical justification. Sexual violation includes more overt sexual contact.

Guidelines for investigating allegations of sexual misconduct cover interviewing, collecting physical evidence, and doing undercover surveillance. Boards are advised to establish special procedures in deference to the sensitivity of the matter to complainants.

Guidelines for conducting hearings cover the initiation of charges, the pros and cons of open hearings, protecting patient confidentiality, and the use of expert witnesses.

The guidelines recommend a comprehensive evaluation of health professionals who may have a physical or mental impairment. The document discusses evaluator qualifications, goals of an evaluation, and elements of the evaluation process.

The guidelines for discipline discuss mitigating factors to consider in crafting a disciplinary order and requiring a current assessment or completing of a course of treatment before considering reinstatement of a license. Guidelines for monitoring discuss workplace supervision, use of chaperones, onsite investigations, practice limitations, counseling, and education.

The document concludes with these thoughts:

Physician sexual misconduct can encompass a wide range of behaviors and can occur in multiple contexts. It is very damaging to patients and patient surrogates, as well as to the integrity of the medical profession.

These guidelines cannot anticipate all possible scenarios. However, they do provide a general set of principles for boards to follow in cases of sexual misconduct.

SCOPE OF PRACTICE

Healthcare Professional Organizations Oppose AMA-sponsored Efforts to Limit Scopes of Practice

Editorial Note: Last Quarter, (Vol. 18 Second Quarter [Summer], 2006) reported on the American Medical Association's (AMA) Scope of Practice Partnership which opposes expanded scopes of practice for a variety of licensed health care professionals. Twenty-five organizations representing some of the professions targeted by the AMA initiative have created a Coalition for Patients' Rights to resist efforts to restrict their scopes of practice. The following article draws on excerpts from documents on the Coalition's Web site and a June 19, 2006 Coalition statement entitled, "Healthcare Professionals Urge Cooperative Patient Care: Oppose SOPP & AMA Resolution 814." For more information, visit http://www.patientsrightscoalition.org.

The Coalition for Patients' Rights (CPR) formed to oppose the AMA's efforts to limit their scopes of practice consists of the following 25 organizations:

American Academy of Nurse Practitioners
American Association of Colleges of Nursing
American Association of Nurse Anesthetists
American Association of Critical-Care Nurses
American Chiropractic Association
American College of Nurse-Midwives
American College of Nurse Practitioners
American Nephrology Nurses Association
American Nurses Association
American Physical Therapy Association
American Psychological Association
American Psychiatric Nurses Association
American Speech-Language Hearing Association
Association of Rehabilitation Nurses
Association of Women's Health, Obstetric and Neonatal Nurses
Emergency Nurses Association
National Association of Clinical Nurse Specialists
National Association of Pediatric Nurse Practitioners
National League for Nursing
National Nursing Centers Consortium
National Organization of Nurse Practitioner Faculties
National Association of Nurse Practitioners in Women's Health
Oncology Nursing Society
Preventive Cardiovascular Nurses Association, and Wound Stormy and Continence Nurses Society

As described on its Web site, the coalition represents:

> **a variety of licensed health care professionals who provide a diverse array of safe, effective, and affordable health care services to millions of patients each year. These competent, well prepared health care professionals complete years of education in their respective specialties, and have long been recognized at the federal and state levels as qualified and essential contributors to the U.S. health system.**

Although they are excellent and indispensable caregivers to a large segment of the U.S. population, these professionals, who are neither medical doctors (MDs) nor doctors of osteopathy (DOs), continually have to fend off efforts by organizations representing MDs and DOs to limit their scope of practice. In the face of organized medicine's latest divisive efforts to limit these professionals' abilities to provide the care they are qualified to give, the CPR was formed for the sake of patients—to ensure that the growing needs of the American health system can be met and that patients everywhere have access to quality healthcare providers of their choice....

"Scope of practice" can be defined as the range of health care-related activities and services that a health care professional is educated, certified or licensed to provide. CPR is committed to advocating for the practice rights of its members for the sake of their patients who rely on them for the many and varied services they provide. Without the contributions of these professionals to patients across the country, and especially to those in rural and medically underserved areas, many patients would be left without essential health care services. The CPR united to prevent this from happening....

A statement on the CPR Web site explains that the 25 groups issued a joint statement that expressed concern about the negative impact on patients if their ability to seek care from advanced practice nurses, psychologists, nurse midwives, chiropractors, and many other licensed, qualified health care providers is limited. The coalition is calling on the AMA and other physician groups aligned with the AMA to cease their divisive efforts to oppose the established practice rights of CPR members. The coalition also seeks an end to legislation at the state level that would reduce provider options for patients.

The CPR is especially concerned about efforts by the AMA and other physician groups that have formed the "Scope of Practice Partnership" to study the work and qualifications of "allied health professionals" in rural and underserved areas.

The coalition questions the objectives of the AMA and other physician organizations when they seek to advise consumers, regulators, policymakers and insurers on the ability of other health care professionals to offer the services they are allowed by law to provide. Health care providers are a critical source of care for patients throughout the United States, especially those who live in rural areas and medically underserved urban areas.

Historically, people who live in rural areas have relied on a strong array of practitioners to meet their health care needs. Advanced practice registered nurses, social workers, and other professions that require rigorous educational preparation and ongoing instruction and certification are the backbone of not just the rural health care system, but the entire health care structure in the United States.

The Coalition's statement, dated June 19, 2006, directly challenges the AMA's Scope of Practice Partnership and Resolution 814 passed by the AMA House of Delegates in November 2005. The resolution reads:

> **RESOLVED,** That our American Medical Association, along with the Scope of Practice Partnership and interested Federation partners*, study the qualifications, education, academic requirements, licensure, certification, independent governance, ethical standards, disciplinary processes, and peer review of the limited licensure health care providers, and limited independent practitioners, as identified in the Scope of Practice Partnership and report back at the 2006 Annual meeting.

Editorial Note: * The "Federation partners" refers to the AMA, organizations with voting representation in the AMA House of Delegates, and the component societies (e.g., state medical societies) that work with each other to pursue common goals.

Addressing the SOPP and Resolution 814, the Coalition's statement says in part:

Patient Safety

Our organizations set the highest standards for patient safety, and numerous studies demonstrate that our members provide safe, high quality care. Neither the SOPP nor Resolution 814 cite any credible evidence that the scopes of practice of our members are unsafe, problematic, or warrant special scrutiny or study. To the contrary, our members are filling a vital need in this country. With shortages in various areas of healthcare, and more than 45 million uninsured Americans, our members are the solution to this country's healthcare challenges, not the problem. Some physician organizations have characterized our efforts to enhance our scopes of practice as a "threat." Far from that, with America's population aging, we are the answer to the challenge of keeping pace with the demand for quality healthcare services. Now is the time to encourage the increased use of all available healthcare professionals to meet the growing demand for affordable, high quality care.

Balanced Study

Physician organizations are not in the best or most objective position to conduct a balanced and fair assessment of education and training standards for other licensed healthcare professions. A balanced study of healthcare professions would include an evaluation of physician scope of practice and consider whether physician scope of practice is overboard. Such a study would also assess whether state laws and regulations governing physician practice contain outdated language that should be eliminated so that the unique skills of licensed healthcare professionals who do not hold a medical license are recognized. The study would also evaluate the implications of current state laws that allow physicians to practice in any specialty, regardless of individual qualifications to do so.

AMA Resolutions Unwarranted/Need for Cooperation Instead

In the past decade, the AMA has adopted at least seven resolutions concerning one or more of the undersigned professions that, if implemented, would restrict our practice and impede patient access to care. The resolutions have been widely ignored. The SOPP appears to signal a renewed effort, buttressed by substantial expenditures, to restrict the practice of healthcare professionals who are not physicians. It is time or the AMA and other SOPP member organizations to recognize that our members have long demonstrated that they provide high quality, safe care and do not warrant the singular and extraordinary scrutiny that the SOPP AND Resolution 815 seem to contemplate. There is more than enough room – and need – for all of us. We need to work together, all of us contributing our respective expertise. This occurs every day in clinical settings, with the many different types of healthcare professionals who we represent cooperating with primary care physicians and various physician specialists. Rather than endlessly attempting to keep healthcare professionals who are not physicians from practicing to their full capability, it is time for SOPP member organizations to join us in advancing a more productive agenda. The winners will be patients.

Healthcare Access

It is ironic that the SOPP seeks to study whether healthcare professionals other than physicians "truly" fill healthcare voids in rural and other underserved areas. It has long been amply demonstrated that if it were not for healthcare professionals other than physicians, millions or patients in rural and underserved areas would not have access to needed services. The SOPP seems to imply that healthcare professionals other than physicians are not necessary unless physicians are not available. This ignores the value and effectiveness of our members, regardless of whether an area is urban or rural. We call upon the AMA and other SOPP members, regardless of whether an area is urban or rural. We call upon the AMA and other SOPP members to join us in finding solutions to America's healthcare problems rather than wasting resources to "study" healthcare professionals who are safe and qualified.

Terminology

Terms such as "allied health practitioner," "limited licensure healthcare provider," or "non-physician" reflect an anachronistic view of healthcare professionals who are not physicians. Our members are not physician adjuncts, and are independently responsible for their actions, regardless of whether physicians are involved.

Summary

We ask the SOPP member organizations to cease their divisive efforts, and work with us to improve access to a wide variety of healthcare professionals who deliver affordable, effective healthcare to patients.

Editorial Note: A June 25, 2006 article by Associate Press writer Joann Loviglio and circulated by Yahoo News contains the following statistics relevant to the practice of Nurse Practitioners:

- The number of nurse practitioners has grown from 30,000 in 1990 to 115,000 today.
- Nurse-managed primary care centers have increased from a handful 15 years ago to 250 nationwide.
- The percentage of third-year residents in medical schools who indicate they intend to pursue careers in general internal medicine has decreased from 54% in 1998 to 20% in 2005.
- A 2000 study published in the Journal of the American Medical Association found that patients who receive their care from nurse practitioners receive comparable care and are just satisfied as patients receiving care from physicians.
- In about half the states, nurse practitioners are recognized by insurance carriers as primary care physicians.
- In all but seven states, nurse practitioners practice either independently or with remote collaboration with doctors.
- In all states except Georgia, nurse practitioners have at least some independent prescriptive authority.
- Nurse practitioner-managed primary care centers are reported to see their patients twice as often as similar practices staffed by of physicians.

Nursing Organization Dedicated to "Full Spectrum Workforce"

The Federation for Accessible Nursing Education and Licensure (FANEL) was founded in 1983 for the purpose of "preserving the present opportunities for nursing education and licensure" by maintaining multiple levels of entry into nursing practice. FANEL embraces the following three positions:

- Support for a "Full Spectrum Work Force" for health care delivery. A "full spectrum" of patient needs that will extend into the twenty-first century and beyond will demand an appropriate skill mix of nursing care that is achieved only by nurses educated at a spectrum of levels.
- Support for economic opportunity and continuous growth. The current four levels of entry into the nursing profession provide a "full spectrum" of choices for economic opportunity for many people from various cultural backgrounds. Continuous growth is encouraged by articulation from one level to the next one at a pace comfortable, both economically and educationally, for the individual nurse, IF she/he so desires.
- Support for the appropriate skill mix of nursing to keep the care but reduce the cost. Health care providers have an economic responsibility to health care consumers and employees. The use of the appropriate nursing skill mix provides situational competency at the lowest cost. At the same time, employees from a "full spectrum work force" are provided economic opportunity for advancement.

Politics Implicated in School Eye Exam Decision

The North Carolina State Senate voted unanimously on June 22, 2006 to repeal a requirement that incoming kindergartners receive a comprehensive eye examination after the sponsor of the legislative requirement was found to have accepted sizeable campaign contributions from his fellow optometrists. Legislation pushed through by NC House Speaker Jim Black would have made an eye exam conducted by an optometrist or ophthalmologist within the previous six months mandatory in order to be admitted to public kindergarten.

Opponents of the comprehensive eye exam requirement contended that children already undergo vision screening before entering school. They argue there is no reason to make parents pay between $65.00 and $120.00 for an additional eye exam.

Substitute legislation is being considered which would expand the time within which a comprehensive eye exam must have been conducted and permit out-of-state doctors to conduct such tests. This bill includes an appropriation to help low income families pay for the screenings.

Expert Witnesses Policed by Boards and Professional Associations

As of July 1, 2006, expert witnesses appearing before Mississippi's medical board are subject to new standards of accountability for their testimony. Witnesses holding Mississippi licenses who give false testimony will be subject to fines and possible action against their license, including revocation. Out-of-state witnesses who testify falsely may be referred to their home state for licensure action. Mississippi authorities may also seek a court order barring the witness from future testimony in the state.

The American Medical Association considers giving expert testimony to be the practice of medicine and therefore subject to medical board discipline. Only a minority of medical boards embrace this philosophy. A grass roots movement of attorneys and professional associations has stepped up to take action against unscientific and false testimony. The American Association of Neurological Surgeons, which has been policing expert witnesses for two decades, is seeing an increase in complaints. The American Academy of Orthopaedic Surgeons recently adopted standards for expert testimony. Professional associations, however, do not have the arsenal of disciplinary tools available to licensing boards. Expulsion from a professional association will not necessarily put a physician out of practice.

Editorial Note: If acting as an expert witness is the practice of medicine, what about serving as a peer reviewer for a scientific journal, or serving on a scientific advisory panel, such as the advisory panels that make recommendations to the Food and Drug Administration, the Institutes of Medicine and the National Academies of Science. Questions have been raised for some time about the objectivity of medical journal peer reviewers who are retained by pharmaceutical companies, medical device manufacturers and other health care corporations. Similar questions about the objectivity of physicians and scientists who serve on FDA advisory panels have prompted the FDA to clarify its conflict of interest policies. Should licensing boards get into this act and declare these activities to be the practice of medicine and therefore subject to licensing board sanction if licensees allow their scientific objectivity to be compromised by financial or other non-scientific influences?

IN THE COURTS

Lawsuit Holding Pharmacists Liable for Warning Patients Allowed to Proceed

The Florida Supreme Court cleared the way for a negligence lawsuit against two pharmacies to go to summary judgment or trial. Robert Powers sued the pharmacies in behalf of his deceased wife who died after taking an inappropriate combination of narcotics provided by the two pharmacies. Powers sued the pharmacies for negligence for not warning his wife about the dangers of taking the medications together. (***See CANews, Vol. 17, No 3, p. 42***)

A County Circuit Court dismissed the lawsuit, but the District Court of Appeal reversed that decision, ruling that it is a pharmacist's duty to warn customers of the risks of filling repeated prescriptions for a combination of drugs that could prove fatal. By refusing to hear the case, the Florida Supreme Court let the appeals court ruling stand.

Hospital Liable for Failure to Disclose Peer Review/Credentialing Information

On May 26, 2006, a jury in federal district court in New Orleans awarded more than $4 million against a hospital and an anesthesiology practice finding them negligent because they failed to report that they had taken adverse actions against an anesthesiologist in response to a credentialing inquiry by the next institution to hire the anesthesiologist in question. The hospital failed to renew the anesthesiologist's privileges and his practice fired him after he had been found diverting narcotics and using them on the job. This information was not passed on to the medical center that next retained the anesthesiologist who continued to abuse drugs and consequently caused a patient to enter a permanent coma.

Courts Examining Legal Protections Surrounding Peer Review

Courts in Florida and California may soon alter some established legal underpinnings of hospital peer review. The issue before Florida courts has to do with the confidentiality of peer review proceedings. In November 2004, Florida voters passed a state constitutional amendment that allows peer review, credentialing and risk management documents to be used in medical liability lawsuits. Two lower courts agree that this voter initiative overrides earlier laws protecting peer review confidentiality. At issue is whether these new rules apply retroactively to cases filed prior to the passage of the constitutional amendment. The Florida Supreme Court may agree to decide this issue and, perhaps, revisit the meaning of the amendment.

Supporters of the amendment point out that public access to peer review records enables consumers to make more informed choices among healthcare providers and to have more complete information about medical errors and adverse incidents. Many physicians worry that if peer review proceedings cease to be confidential, doctors will be even more reluctant to report errors.

The issue before the California Supreme Court has to do with the legal protections afforded to peer review committees against frivolous lawsuits. Two appeals courts took opposite positions on whether a state statute intended to stop strategic lawsuits designed to interfere with "official proceedings authorized by law" or speech "in connection with a public issue" applies to peer review committee activities. Both lawsuits arose when physicians sued peer review committees for defamation and wrongful suspension of privileges. One appeals court ruled that peer review committees are not an independent public agency, but are instead private entities concerned not with the public at large, but only with the patients of a particular hospital, so they can be sued for defamation. The other court concluded that peer review proceedings are official acts under the California Business and Professions Code and are immune from defamation lawsuits.

The California Medical Association (CMA) and the state's hospitals disagree over the implications of the state supreme court's decision. CMA worries that if peer review is given additional protections, physicians who are wrongly censured will have no recourse against the peer review committee. Hospitals argue that peer review committees need the maximum protection so that physicians will be willing to serve on them.

BOARD ASSESSMENT

Illinois Medical Board Disciplinary Process Found Wanting

The Illinois Auditor General, William Holland, issued a critical audit of the state's medical board on August 8, 2006. The audit's findings include:

- Fifteen percent of cases are closed without evidence that the board has signed off on the closing. Intake staff dismiss some cases, and others are closed by investigators without evidence of board approval.
- Investigators do not always have access to prior complaints against physicians under investigation.
- Fifty percent of investigations take longer than the department's goal of five months.
- Staff shortages interfere with the board's ability to police the profession and to monitor compliance with probation orders.
- The board is not complying with requirements that it post on its Web site physician profiles, including complete disciplinary records.
- Although the board is supposed to have four public members, all these positions have been vacant since March 2005.

The Department of Financial and Professional Regulation challenged some of the auditor's findings. They say, for example, that the lack of evidence of the board's approval of case dismissals is due to missing paper work, and that investigators possess complete information about physician complaint histories.

On August 8, 2006, the Associated Press circulated the following list of key recommendations followed by the department's response:

- Record all allegations and forward them to investigators. (Response: Agree, except when complaints clearly cannot be investigated.)
- Have Medical Disciplinary Board approve all decisions to close investigations. (Response: Agree.)
- Adopt timelines and other procedures to speed up investigations. (Response: Under review.)
- Include information about past complaints in investigative files. (Response: Already being done.)
- Eliminate backlog in medical recommendations to the disciplinary board. (Response: Done.)
- Develop disciplinary criteria so that similar violations receive similar punishments. (Response: No, it would be illegal and take away valuable flexibility.)

- Improve monitoring of doctors whose licenses have been suspended or revoked. (Response: Changes in drug and alcohol testing soon will give probation staff more time to monitor doctors.)
- Send disciplinary reports to all health facilities, medical associations and liability insurers, as required by law. (Response: Report available online or via e-mail.) Post doctor profiles and disciplinary information online, as required by law. (Response: Underway, with some information already available.)
- Post doctor profiles and disciplinary information online, as required by law. (Response: Underway, with some information already available.)
- Fill four vacant board seats meant for members of the public. (Response: Trying to find volunteers.)Fill four vacant board seats meant for members of the public. (Response: Trying to find volunteers.)

CONTINUING COMPETENCE

UK Medical Regulators Call for Annual "Revalidation"

Editorial Note: On July 14, 2006, Sir Liam Donaldson, the Chief Medical Officer of the United Kingdom's General Medical Council issued a 218 page report entitled, "Good Doctors, Safer Patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients." This article consists of excerpts from the report's executive summary and the chapter entitled, "Assessing Clinical Practice." CAC is impressed by the candor of the report and the scope and good sense of its recommendations.

Summary

There are around 130,000 registered doctors in active practice in the United Kingdom. The vast majority practice medicine of very high quality. A small proportion practice at a standard that is not acceptable, whether through inadequate training, insufficient support, ill health, lack of motivation, or, on rare occasions, malice. Most doctors know of another doctor whom, on balance, they would prefer not to treat their own family. Unsatisfactory practice compromises patient safety. The medical profession has a duty to identify such practice and to remedy it. The profession owes this not only to patients, but also to itself....

The current system of regulation of doctors aims to provide an assurance that each of these doctors, whatever their clinical role and practice setting, is safe and performing to an acceptable standard. The scale of the task is huge and the complexity daunting. The main body responsible for it is the General Medical Council, but the medical Royal Colleges and other professional bodies also play important roles, particularly in relation to standard setting, education and training.

The system of medical regulation and the structures and processes for assuring and improving the quality of care and patient safety in local health services have not related well to each ether in the past. This needs to change: they need to work together effectively and efficiently to promote good

practice, and to ensure that poor practice is not overlooked or ignored and does not fall into "grey areas" of inaction.

The end result of the changes proposed in this report must be that patients, the public, the medical profession, employers and other contracting organizations become able to trust that every doctor will deliver good clinical care throughout their careers....

The General Medical Council has led a series of reforms to its structure and procedures through the late 1990s to the present day. Lay participation in the work of the Council, its committees and its fitness to practice panels has increased. The size of the Council has been reduced and its composition altered. Fitness to practice procedures have been streamlined, and public access to information has been enhanced. Another major reform was also proposed: revalidation, a new system that would enable each doctor to have their fitness to practice reviewed every five years and their license to practice renewed only if they satisfied the requirements of that review....

The scale of the problem of poor performance is better to understand now than previously. It may occur for a variety of reasons, which may be particular to doctors themselves or a result of the interplay between them and their wider working environments. The reasons include inadequate training and support, poor motivation, behavioral misconduct, a stressful workplace, poor relationships within a clinical team and physical or mental ill health....

Medicine is not the only safety-critical industry in recent times to reflect upon its regulatory framework following a series of significant events. The nuclear industry responded to events at Chernobyl by revisiting the arrangements in place for regulation, as did the offshore oil industry after the explosion on board the Piper Alpha platform. The civil aviation industry also developed a new system for the quality assurance of pilots at a time when its safety reputation was flagging.

Nuclear power plant desk operators, oil installation managers and pilots are all regulated, and the systems in operation are very different to those in healthcare: in all three industries, practitioners are regularly assessed against demanding and objective standards. Failure is greeted by remedial action, not ridicule or shame. Multiple sources of data are utilized in order to triangulate information and confirm impressions. Responsibility for regulation is often devolved to the workplace. Practitioners take pride in their license to practice and employers value the role that practitioner regulation can play in the wider quality improvement agenda. Regulation in these industries may be expensive but the fruits, in terms of quality and safety, far outweigh this cost....

To the extent that a worldwide trend can be identified, medical regulation is moving from the premise of pure self-regulation to one of regulation in partnership between the profession and the public. Regulatory bodies are becoming more accountable, lay involvement is much increased and adjudication is often an independent function. Whilst there are moves toward ongoing assessment of competence, there is no model whereby such assessments are explicitly and universally linked with a practitioner's ability to practice. Medical regulators have come to be positioned within the wider quality assurance framework: they no longer stand detached.

Few members of the public claim to know a great deal about he ways in which the ongoing competence of doctors is assured; many believe that a satisfactory process must already be in place and almost all feel

that regular assessment is appropriate. The majority of doctors whose views were sampled also agreed that regular assessment should take place. Both the public and doctors have firm views as to which aspects of practice can and should be assessed: these views are not very different. Furthermore, the public wants the assessment of doctors to go beyond technical skills to address the doctor's communication skills, whether or not the doctor is up to date, whether the doctor involves patients in treatment decisions and whether the doctor affords their patients dignity and respect....

Methods of assessment are better developed than in generally realized. Valid, reproducible and objective measures of knowledge, skill and clinical performance are now used within some undergraduate and postgraduate training programs. However, there are only a few examples of their use at a more senior level and a view persists that reliable assessment is a dream rather than a reality.

Chapter Five: Assessing Clinical Practice

Key Points in this Chapter:

- There is a consensus that the quality of an individual doctor's practice cannot be taken for granted and needs to be assessed. This happens in training posts but not for doctors in career grades who may have no formal assessment of their practice in their entire career.
- Well-developed systems of assessment are in use to assess doctors whose performance is causing concern but these have not been deployed more widely.
- Assessment models in undergraduate and postgraduate training have changed markedly in the last 15 years and now offer improved objectivity and transparency, and the scope for wider use (for example, the Objective Structured Clinical examination or OSCE format).
- There are many routine sources of data that have the potential to offer an insight into practitioner performance and the quality of care but these are largely being used for purposes other than assessment.
- There is a great deal of interest internationally in developing formal codes of practice to provide a standard as to what is expected of a "good" doctor.
- Systems for monitoring death rates in primary care have been proposed but not systematically implemented.
- Techniques for simulating actual practice situations are developing rapidly, particularly in the fields of anesthetics and surgery.
- The true prevalence of performance problems is difficult to determine, especially where ill health and addiction are concerned.
- Sick and addicted doctors are not all recognized, and sources of help are fragmented and of variable effectiveness.
- The one-year risk of referral to the National Clinical Assessment Service is approximately 0.5% for all doctors and rises to 1% for those in the most senior posts: over 1,700 doctors were referred between 2001 and 2005.

- Over 500 alert letters have been issued since 1997, warning the NHS of practitioners who pose a threat to patient safety.
- Each year, approximately 300 doctors appear for the first time before fitness to practice panels operated by the General Medical Council.
- The assessment methods developed by the National Clinical Assessment Service for cases of poor practice have a wider applicability to affirming safe practice...

Is appraisal assessment?

The requirement for there to be an annual appraisal for every NHS doctor in a career grade post was proposed in my report *Supporting Doctors, Protecting Patients,* and implemented for hospital and public health doctors in 2001 and for general practitioners the year after. Arrangements differ for doctors employed in the private sector but many are involved in some system of annual appraisal.

The idea of appraisal and its underpinning philosophy has proved particularly contentious. By and large, doctors have valued the opportunity that annual appraisal provides to reflect on their practice and identify scope for professional development but only in so far as it is a formative (i.e. developmental) process. Suggestions that appraisal could ever be summative (i.e. judgmental about the standard of an individual's performance) is an anathema to some medical professional bodies and individual doctors. Yet, Dame Janet Smith in *The Shipman Inquiry: Fifth Report* condemned the NHS system of annual appraisal because it failed to carry out any assessment or make any judgments....

Having empirically identified best practice, the methodologies for carrying out appraisal (contained within the national guidance for appraisal) were arrived at through negotiation with the main trade union, the British Medical Association, rather than being firmly rooted in research evidence....

Essentially, the appraisal process in primary care is currently heavily reliant on the general practitioner's self-assessment because the doctor carrying out the appraisal will have little first-hand knowledge or information about their colleague's work or day-to-day performance in the job. Anecdotal accounts suggest that where the management of a primary care trust has concerns about the standards of a general practitioner's care, more often than not, such individuals have "good" appraisals on file.

Conclusions

The need for transparent and objective assessment of clinical performance during training is now well established. The means by which to deliver such assessment are evolving but need to develop further.

Many promising tools have been designed in order to produce assessment that is more objective and structured: these include high-fidelity simulators. Assessment can cover both technical and non-technical aspects of performance.

The place of assessment for doctors established in career posts is currently less well defined, but many professional bodies have made a promising start in determining how best to assess practitioners to ensure continuing competence.

The place of professional codes is an area that has been much discussed, although there are several examples of sets of standards for doctors, these have not been effectively operationalized for day-to-day use as formal codes of practice.

Numerous existing sources of data have the potential to aid the assessment of individual practitioners. Many of these data are currently collected for another prime purpose.

The degree to which ill health adversely affects the performance of doctors is uncertain. Specialized treatment programs may offer improved outcomes: further research and audit would be helpful....

The exact extent of poor performance is difficult to determine but the work of the National Clinical Assessment Service has been extremely informative in describing the scale and nature of the problem. Both the National Clinical Assessment Service and General Medical Council operate performance assessment procedure.

The entire report can be found online at http://www.dh.gov.uk/PublicationsAndStatistics.

Nursing Board Answers FAQs about Continuing Competence

The North Carolina Board of Nursing ran the following article in its Summer ***NURSING BULLETIN*** answering Frequently Asked Questions about Continuing Competence:

Question 1: I renewed by license in July 2006. I work in critical care, and my learning goal for my 2006-2008 licensure period is to obtain national certification in critical care nursing. I've chosen to accomplish this through successful completion of the required examination. What documentation will I need to retain and provide as evidence if I'm selected for audit at my next renewal in July 2008?

Answer 1: If audited in July 2008, you will be expected to provide a copy of your active certificate, which should include your name, the name of the certifying body, the date of certification, and the date of certification expiration. For your certification to be acceptable as a learning goal that you have accomplished, you must have initially attained it during the licensure period, or you must have been recertified during the licensure period.

Question 2: I will renew my license in May 2007. I am currently a stay-at-home mother, but I previously worked in pediatrics and plan to return to that specialty when my children are older. My learning goal for my 2007-2009 licensure period is to maintain and enhance my knowledge of the nursing care of children while I am not actively employed. I've chosen to accomplish this through completion of 30 contact hours of online and nursing journal continuing education offerings. What documentation will I need to retain and provide as evidence if I am selected for audit at my next renewal in May 2009?

Answer 2: If audited in May 2009, you will be expected to provide copies of the continuing education certificates (totaling 30 contact hours) that you obtained on successful completion of each online or journal offering. The certificates should include your name, the title of the educational activity, the name of the recognized provider, the number of contact hours, and the date of the activity.

Question 3: I've seen information about professional portfolios. Am I required to purchase or subscribe to a professional portfolio system to document and submit my continuing competence to the Board?

Answer 3: No, you are not required to use a professional portfolio system (electronic or paper-based) for documentation and submission of your continuing competence. Although it is important that you maintain documentation of continuing education and professional activities for ready access if you are audited, you may do so in any manner of your choosing. Some licensees may find portfolio systems to be an attractive, effective record-keeping option, but such systems are not required or offered by the Board of Nursing.

Editorial Note: The North Carolina Board of Nursing has made a noteworthy first step toward continuing competency assurance, even though the board still relies heavily on continuing education rather than more meaningful demonstrations of ongoing competence. We look forward to seeing the board's continuing competency program strengthened in the future.

BOARD MEMBERSHIP

Alabama Chiropractic Board to Have Minority Member

The July 2006 newsletter of the Alabama State Board of Chiropractic Examiners (ASBCE) reported on code changes affecting the profession, including one that alters the composition of the board.

This change creates a new position on the Board for a minority member. The ASBCE was one of the last, if not the last, State Board or Commission that did not have minority representation other than females. The ASBCE has been under fire from the legislature for several years to rectify this situation, and came to the conclusion that if we did not propose an equitable remedy to

this situation then the legislature would do it for us, possibly by returning the Board to selection by political appointment. The solution proposed and passed by the legislature allows for a new member to be elected by DCs from the state at large. Therefore, this fall, Congressional Districts 5 and 6 will elect new members, as usual, and all the DCs in the state will elect the new minority member.

HORROR CASE OF THE QUARTER

New Hampshire Medical Board Stopped from Disciplining Doctor for Insulting Patients

In a decision released on July 6, 2006, Superior Court Judge Edward Fitzgerald ordered the New Hampshire Board of Medicine to halt proceedings against Dr. Terry Bennett. Bennett has been accused of several displays of astonishing disrespect for a patient. One patient recovering from brain surgery in 2001 complained to the medical board that Bennett told her to buy a pistol and shoot herself to end her suffering.

Another patient complained in 2004 that Bennett told her she was so obese she might be attractive only to black men. According to the patient's complaint, Bennett said to her, "Let's face it, if your husband were to die tomorrow, who would want you? Well, men might want you, but not the types you want to want you. Might even be a black guy."

In ordering the medical board to stop its disciplinary investigation, Judge Fitzgerald wrote that although he did not condone Bennett's alleged remarks.

It is nonetheless important ... to ensure that physicians and patients are free to discuss matters relating to health without fear of government reprisal, even if such discussions may sometimes be harsh, rude or offensive to the listener.

In support of his conclusion, Fitzgerald pointed out that the board's own Web site alerts consumers that: Complaints regarding high fees, rudeness or "poor bedside manner" do not ordinarily violate one of the above provisions unless they also involve dishonesty or exploitation or gross negligence on the part of the physician.

Bennet's reaction to the judge's ruling was to declare victory and threaten to sue everyone involved in the case for "malicious prosecution."

Editorial Note: CANews & Views is shocked by the judge's decision to stop the medical board from pursuing this case. However much we respect the right to free speech, we are alarmed that a regulatory board could be forced into inaction against a practitioner so free with outrageous insults to the patients in question as well as to people of color.

Reacting to the attention attracted by the Bennett case, American Medical News published an article in its August 14, 2006 issue on physician ethics and bedside manner. AMNews Staff writer Damon Adams quotes medical ethicist, Denise M. Dudzinski, who says patients have different levels of tolerance for someone who is being candid as opposed to being unkind. While Bennett justified his extreme remarks by saying he has to shock patients into overcoming their denial, the physicians and ethicists Damon Adams interviewed tended to feel this kind of "candor" is likely to be counter-productive, at best.

CONSUMER INFORMATION

Study Finds Quality Information Incomplete

A study published in the July 5, 2006 Journal of the American Medical Association (JAMA) concluded that the comparative process quality information disseminated by the Centers of Medicare and Medicaid Services (CMS) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), does not provide enough information for consumers to make fully informed choices. Entitled, "Hospital Quality for Acute Myocardial Infarction: Correlation among Process Measures and Relationship with Short-term Mortality," the study was conducted by Elizabeth H. Bradley and nine other researchers.

The researchers wanted to learn how the CMS and JCAHO process measures for acute myocardial infarction (AMI) correlate with each other, and the degree to which inferences about a hospital's outcomes can be made from its performance on publicly reported processes. They assessed hospital performance in the CMS/JCAHO AMI core process measures using 2002-2003 data from 962 hospitals participating in the National Registry of Myocardial Infarction (NRMI) and correlated these measures with each other and with hospital-level, risk-standardized, 30-day mortality rates derived from Medicare claims data.

They found moderately strong correlations for comparisons between beta-blocker use at admission and discharge, aspirin use at admission and discharge, and angiotensin-converting enzyme inhibitor use. There were weaker, but statistically significant, correlations between these medication measures and smoking cessation counseling. Even though some process measures were significantly correlated with risk-standardized, 30-day mortality rates, they still explained only 6.0% of hospital-level variation in risk-standardized, 30-day mortality rates for patients with AMI.

As a result, the researchers concluded that the publicly reported AMI process measures capture a small proportion of the variation in hospitals' risk-standardized short-term mortality rates. They recommend that additional measures that reflect a variety of processes and also *outcomes*, such as risk-standardized mortality rates, are needed to characterize hospital performance more fully.

Consumers Don't Use Performance Data to Choose Providers

Editorial Note: The following item is reprinted with permission from the June 2006 issue of HealthFacts, the monthly newsletter of the Center for Medical Consumers.

Publicly Available Surgeon-Performance Info Does Not Affect Consumer Choices

Give the public access to what is known as physician-performance data, and people will choose top quality care accordingly. Such was our vision when the Center for Medical Consumers started over 30 years ago, but things do not always work out as planned. This was demonstrated most recently by a study reported in the May/June issue of the academic journal, ***Health Affairs***.

Ashish K. Jha and Arnold M. Epstein of the Harvard School of Public Health examined the impact of the New York State Coronary Artery Bypass Surgery Report-Card System. They described the program as "arguably the gold standard for the public reporting of

hospital and physician quality." Coronary artery bypass surgery is a particularly good one to study because there is considerable evidence to show that people facing this operation can cut their chances of dying in half – if they pick a top-performing hospital or surgeon. Furthermore, studies have shown a correlation between high volume and high quality.

In other words, surgeons who perform the most bypass operations tend to have the lowest operative death rates.

Jha and Epstein collected information from the New York State Report Card System for bypass operations performed at 33 hospitals between 1989 and 2002, the most recent year for which data were available.

Given the expense, major complications, and deaths associated with bypass surgery, Jha and Epstein thought that the report-card system would be expected to influence patients' decisions and cardiologists' referral practices. After all, this operation is only infrequently done on an emergency basis. "We found no evidence that purchasers or patients are using these reports to drive market share to higher performing providers," concluded Jha and Epstein. However, the surgeons with the highest mortality rates were much more likely than other surgeons to retire or leave practice after the release of each report card.

Researchers Study Communicating About Evidence-Based Health Care Decision-Making

The first phase of a study of evidence-based health care decision-making, funded by the California HealthCare Foundation and conducted by Karen Shore and Kristin Carman of the American Institutes for Research, was published April 4, 2006.

The first phase consisted of an environmental scan, including literature and Web site reviews and telephone interviews with individuals who "regularly engage consumers about health care topics." Future phases of the study will include developing and testing evidence-based health care messages and creating a tool kit for intermediaries to use to communicate with consumers.

Key findings from the first-phase environmental scan include:

- Evidence-based health care (EBHC) decision-making is a desirable but challenging goal.
- There is a consensus in the literature and among experts that EBHC decision-making by employees and other consumers is desirable. Potential benefits may include improved quality of care, cost savings, and better health outcomes.
- Challenges to the widespread adoption of EBHC decision-making include terminology that does not resonate with consumers and a lack of solid evidence for many treatments and conditions.
- Messages to consumers are more likely to be received by certain types of consumers, and messages containing information at a disease or condition level are more likely to be heard.
- Certain types of consumers (e.g., people with chronic diseases) are more likely to seek out evidence than others....

- Certain topics within EBHC are more likely to resonate with consumers than others. Topics such as improved safety and transparency... resonate; cost savings does not. Consumers are most likely to resist messages regarding overuse; they are more likely to accept messages regarding under-use and misuse.
- Effective messengers about EBHC are those perceived as objective and credible, and messages will likely need to be delivered through partnerships between organizations.
- The goals of efforts to communicate with consumers about EBHC vary; however, a threat to provider trust is a potential result.

One of the goals of efforts to engage consumers on EBHC is to encourage them to engage in a dialogue with their health care providers about medical decisions, including asking questions of the providers. There are many who believe that this information will allow the consumer to be a more informed partner with the provider in making health care decisions. There are others who believe that the informed consumer should be the ultimate decision-maker. In either case, placing the consumer in a questioning role may, paradoxically, jeopardize the trust between patients and physicians. If the goal is for the consumer to be the ultimate decision-maker, this may be too much of a burden for many consumers and may undermine the professional role of the physician.

Editorial Note: The overall goal of this project is to develop recommendations and materials to inform efforts by employers, labor unions, and other stakeholders to communicate with consumers about evidence-based health care decision-making. CAC believes that regulatory boards and specialty certifying agencies are among the other "stakeholders" that should want to be part of this important information-dissemination collaborative. One important contribution professional licensing boards and certifiers can make is to try to avoid any potential collision between an informed, assertive consumer and his or her health care providers as envisioned in the final bullet quoted above.

NCQA Seeks Public Input on Accreditation Standards

On August 15, 2006, the National Committee for Quality Assurance (NCQA) distributed a press release seeking public comment on accreditation standards designed to allow consumers, purchasers and regulators to directly compare the quality of health plans. Excerpts from the press release appear below:

NCQA is working to help Americans better compare their health plan choices by developing a common set of quality standards to measure all health plans. The organization is reaching out to the health care industry, employers, consumers, public purchasers and others to gain input on how best to align accreditation standards for several types of health plans and drive greater improvement in the performance of the U.S. health care system.

Currently, 64.5 million Americans are enrolled in health plans that report performance data, providing consumers, employers and others with information to help them understand how well these plans deliver care that meets evidence-based guidelines. But more than 130 million people are in plans that do not report such data....

Current NCQA MCO Accreditation standards evaluate performance for care management and health improvement and results based on the Health Plan Employer Data and Information Set (HEDIS), the industry standard for measuring clinical performance. Current PPO Accreditation standards do not include such requirements. By measuring and reporting HEDIS results, NCQA has helped drive significant improvement in the quality of care.

PPOs can be organized differently than HMOs. PPO customers are more likely to be national employers and to be self-insured. These structural differences raise some key questions to be considered as NCQA moves toward a single set of standards for different health plan types. NCQA is talking with consumers, employers, health plans and other stakeholders to understand how best to proceed on such key questions as:

- What is the appropriate unit for accreditation? Should national PPOs be accredited at that level or at a state level?
- What are the appropriate levels of HEDIS and CAHPS reporting (e.g., national, regional or state)?
- How should differences in benefits be addressed? How can NCQA best differentiate plan performance in its public reports?

Organizations or individuals interested in providing such perspective should visit http://www.ncqa.org/accred08.

QUALITY OF CARE

Professor Examines Impact of Advances in Quality and Information Technology

Editorial Note: See also the section on Consumer Information for additional articles related to the impact of quality information.

In a commentary appearing in the June 21, 2006 issue of the ***Journal of the American Medical Association*** (JAMA), Professor Robert Wachter, MD of the Department of Medicine, University of California, San Francisco, explores the "Expected and Unanticipated Consequences of the Quality and Information Technology Revolutions." Insurers and the Centers for Medicare and Medicaid Services (CMS), he begins, have determined that measuring and publicly reporting quality indicators are keys to promoting evidence-based care, reducing medical errors, and tackling geographic and ethnic disparities in care.

The timing is opportune, he points out, because of advances in measuring three aspects of quality: the *structure* according to which care is organized, the *process* by which an intervention is done, and the *outcome* for the patient. At the same time, advances in information technology enable health care institutions to gather and analyze all three dimensions of quality data.

The bulk of the article is devoted to describing some unforeseen consequences of these quality and information technology revolutions:

Practitioners and institutions focus on improving the variables that are measured and publicized while turning away from other variables. He cites three examples of this.

The first example involves administering pneumococcal vaccinations (a quality measurement) to patients for whom there is no record of previous vaccination, even though this practice results in some patients receiving unnecessary duplicate vaccinations.

A similar example has to do with administering antibiotics within the first four hours a patient is hospitalized (a quality marker), even in cases where the diagnosis is not yet complete. This practice results in antibiotics being given to patients who ultimately turn out not to have pneumonia.

The third example involves non-physician case managers who remind physicians to attend to the publicly measured care processes, sometimes before problems that are more urgent are taken care of.

The current science of quality measurement cannot adequately deal with complex, multi-organ system disease. If the care for such patients followed the evidence-based practice guidelines for every medical condition, they could be harmed by multiple potentially incompatible medications and the cost of their care would be insupportable. Dr. Wachter observes that the science of quality measurement needs to mature to be able to assess the quality of care for patients with multiple disorders. He believes quality measurements need to expand beyond evidence based to include performance caring for patients with multi-organ illness, practicing in teams, safely performing procedures, performing in simulated scenarios with simulated patients, and maintaining board certification

Computerized health care is not a panacea. There have been instances of practitioners prescribing the wrong medication from a computerized pick-list. He cites an example of two patients' bar coded wristbands becoming switched almost resulting in a non-diabetic patient being injected with insulin meant for his bed neighbor. Doctors and nurses learning computerized systems have been known to spend time at the computer screen at the expense of patient care. Practitioners need to buy in to computerized systems and be assured they will not compromise efficiency.

Wachter concludes that safe, evidence-based care depends on having excellent practitioners. It also depends on a work environment - or system - for these excellent practitioners, which is governed by rules, regulations and infrastructure support, such as computer systems. He is not persuaded by those who argue that structured systems and practitioners who follow evidence-based guidelines will produce rote medicine where practitioners are interchangeable. He believes there will always be room for art in medicine. He cites as examples, caring for complex cases, patient counseling, ethical decision-making, care coordination, and palliative care. He believes that quality measurement and information technology have a constructive role to play.

MEDICAL ERRORS AND PATIENT SAFETY

IOM Recommends Steps for Preventing Medication Errors

The Institute of Medicine's latest report on medical errors entitled, ***Preventing Medication Errors***, documents the problem and makes recommendations for action by a variety of stakeholders, including consumers, providers, government agencies and regulators, accreditors, and legislators. The Committee on Identifying and Preventing Medication Errors which authored the report estimates that on average a hospital patient is subject to at least one medication error per day, and that at least one quarter of all adverse drug events (ADEs) are preventable.

The Committee identifies a number of patient rights related to medication management:

- to be the source of control for medication management decisions affecting them;
- to accept or reject medication therapy based on personal values;
- to be adequately informed about medication therapy and alternatives;
- to ask questions to better understand their medical regimen;
- to receive consultation about their medication regimen in all care settings and at all points along the medication process;
- to designate a surrogate to assist with medication management;
- to expect providers to tell them when a clinically significant error has occurred, what effects of the event on short- and long-term health will be, and what care they will receive to restore their health;
- to ask their provider to report an adverse event and give them information about how they can report the event themselves.

The report also lists actions consumers can take to enhance medication safety at home, in an ambulatory care setting, at the pharmacy, and as an inpatient. These actions include:

- maintaining a list of all medications being taken and having that list available when visiting a health care provider;
- asking prescribers to write down the name, dosage, and other information about prescribed medications;
- seeking counseling at pharmacies about how to properly take a drug, side effects and what to do about them;
- refusing to take a drug unless being told the reason for doing so;
- prior to discharge from a hospital, asking for a list of the medications to take at home and instructions for how to take them.

The committee recommends actions that providers – physicians, nurses and pharmacists – should take to help prevent medication errors. Most have to do with effective communication with patients:

- reviewing the patient's medication list routinely and during care transitions;
- reviewing different treatment options;
- reviewing the name and purpose of the selected medication;
- discussing when and how to take the medication;
- discussing important and likely side effects and what to do about them;
- discussing drug-drug, drug-food, and drug-disease interactions;
- reviewing the patient's or surrogate's role in achieving appropriate medication use;
- reviewing the role of medications in the overall context of the patient's health.

Other recommendations for providers include the use of information technology, including electronic prescribing and monitoring in all care settings to help reduce errors such as those resulting from prescribers selecting inappropriate medications or nurses and pharmacists failing to read prescribers' handwriting.

The committee recommends that federal government agencies should enhance the resource base for consumer-oriented drug

information and medication self-management. Specifically, they recommend standardizing pharmacy medication information leaflets, improving online medication resources, establishing a national drug information telephone helpline, developing personal health records, and developing a national medication safety dissemination plan.

In connection with oversight, regulation and payment, the committee recommends the use of legislation, regulation, accreditation, and payment mechanisms and the media to motivate the adoption of practices and technologies that can reduce medication errors, and ensure that professionals have the competencies required to deliver medications safely. Specifically, they recommend that regulators, accreditors and legislators set minimal functionality standards for error prevention technologies.

They recommend also that boards of pharmacy undertake quality improvement initiatives related to community pharmacy practice. The Massachusetts Board of

Registration in Pharmacy, for example, issued best-practice recommendations in 2001 intended as standards of professional practice for pharmacies to implement. One standard calls for incident reports to be submitted to the United States Pharmacopeia Medication Errors Reporting System. In 2005, the Massachusetts board issued regulations requiring all pharmacies to establish continuous quality improvement programs. The New York pharmacy board requires continuing education on the topic of medication errors and the Pennsylvania board is expected to enact a similar regulation. The New Mexico Board of Pharmacy requires dispensing errors associated with ADEs to be reported to the board and includes information about preventing medication errors on its Web site.

The full report is available from the National Academies Press (http://www.nap.edu).

Older Surgeons Prone to More Errors

Research published in the September issue of ***Annals of Surgery*** found that surgeons older than 60 years, particularly those who perform few surgeries, are more prone to errors than their younger counterparts for three types of complicated surgery: heart bypass, carotid artery, and pancreas removal. Older surgeons who maintain a high volume of surgeries are less likely to have errors than those who taper off in the years before retirement. Age did not make a significant difference in five other types of surgery studied based on 461,000 Medicare patient files.

These findings are of concern because the number of surgeons over 65 is increasing. In addition, not all hospitals adequately monitor surgeon performance and confront those who have problems.

Editorial Note: The findings of this study are another bit of evidence supporting the need for regular, periodic assessment and verification of the ongoing competence of surgeons as well as all other health care practitioners.

New Nurse Error Rates Affected by Location of Practice and Educational Preparation

The National Council of State Boards of Nursing (NCSBN) recently published a report entitled ***Transition to Practice: Newly Licensed Registered Nurse (RN) and Licensed Practice / Vocational Nurse (LPN /VN) Activities,*** by Kevin Kenward, PhD and Elizabeth H. Zhong, PhD. MEd. The study looked at preparation for practice, including education, internships, externships, preceptorships, mentorships, and orientation of newly licensed nurses.

One facet of the study looked at the relationship between preparation for practice and involvement in incidents or occurrences that resulted in patient harm.

More than half the nurses studied (53.5% if RNs and 47.5% of LPN /VNs) were involved in errors – either as the person making the error, the supervisor of someone making an error, or the person who discovered an error made by other practitioners. More LPN/VN respondents reported errors involving patient falls, while more RNs were involved in errors associated with delays in treatment. More RNs (53.3%) who work in rural areas were involved in medication errors compared to RNs who work in urban areas (39.4%) and suburban areas (37.9%). More RNs working in rural areas reported involvement in errors involving falls (29.5%) compared to RNs in urban areas (15.5%).

In terms of preparation for practice, LPN /VNs who rated the adequacy of preparation to "provide direct care to six or more clients" and to "know when and how to call a client's physician" were significantly less likely to be involved in errors. In addition, RNs who rated their classroom preparation related to "synthesizing data from multiple sources in making decisions" and "teaching clients" were less likely to be involved in errors. In addition, LPN /VN respondents working in rotating shifts were more likely to be involved in errors.

The study asked respondents to comment on the workplace variables influencing the likelihood of errors. More than half of RNs (55.4%) and LPN / VNs (57.1%) responded that inadequate staffing contributed to errors. More than 40% of both groups also identified lack of adequate communication as an important factor causing errors. More LPN /VN respondents believe lack of education (orientation and continuing education) or lack of supplies and equipment contribute to errors. More RNs cited lack of support from other departments, such as pharmacy or food services, as a cause of errors.

The full research brief is available from the National Council of State Boards of Nursing, 111 E. Wacker Drive, Suite 2900, Chicago, IL 60601-4277; **http://www.ncsbn.org.**

IN DEPTH: AARP Public Policy Institute Publishes CAC-authored Study Recommending State-based Requirements for Continuing Competency Assessment and Assurance

Editorial Note: This Quarter's In-Depth Feature is drawn from the Executive Summary of a study entitled, Implementing Continuing Competency Requirements for Health Care Practitioners, written by CAC's David Swankin, Rebecca LeBuhn and Richard Morrison and published by AARP's Public Policy Institute. The full document is available for download at http://www.aarp.org/research/health/carequality/2006_16_competency.html. Hard copies are available by request at mailto:ppi@aarp.org, or by calling (202) 434-3840.

EXECUTIVE SUMMARY

I. BACKGROUND

Over the past half-century, authorities on health professional education, licensing, and accreditation have consistently recommended that state professional licensing boards address the continuing competence of health care practitioners with as much vigor and integrity as they exercise in examining the qualifications of candidates for initial licensure. During the past decade, these calls for rigorous assessment and demonstration of continued professional competence have come in response to evidence of widespread preventable medical errors and other problems with health care quality. Authoritative public policy experts have joined earlier critiques of health professional licensure in advocating that state boards institute programs for assuring the current competence of all health care professions. In this study, three experts affiliated with the Citizen Advocacy Center (CAC) present their recommendations for implementing state-based requirements for continuing competency assessment and assurance as a prerequisite for licensure renewal. These recommendations stem from several key assumptions: problems exist with both patient safety and health care quality; practitioner competence is as important as system safety; regulators and certifiers do not currently assure the continuing competence of health care professionals; and state licensure boards are the logical entity to be charged with assuring continuing professional competence.

1) Problems exist with both patient safety and health care quality. Among the institutions focusing on the need to improve health care quality and to address serious problems affecting patient safety is the Institute of Medicine (IOM), which estimated in its 1999 report, To Err Is Human: Building a Safer Health System, that "between 44,000 and 98,000 hospital patients die each year from preventable medical errors." Two years later, the IOM issued a sweeping critique of the U.S. health care system in its report, Crossing the Quality Chasm—A New Health System for the 21st Century.
2) Practitioner competence is as important as system safety. Systems for periodic assessment and verification of the continuing competence of all health care professionals are needed as well. Individual competence—which includes technical knowledge, practical skills, clinical performance, proper attitude, judgment, and ethics—is as much a systems issue as is error prevention.

3) Regulators and certifiers do not currently assure continuing competence. The public cannot be assured that health care professionals who demonstrated minimum levels of competence when they earned their licenses continue to be competent throughout their careers. With very few exceptions, state statutes do not empower boards to require demonstration of continuing competence as a condition of licensure renewal.

4) State licensure boards are the logical entity to assure continuing professional competence. To address the global concerns of safety and quality of care, tested and feasible requirements for continuing competency assessment and assurance must be compulsory for all health care practitioners. The logical agent to impose requirements for universal competency assessment and assurance is the health professional licensing board in each state. These entities are the only ones with legal authority over all practitioners within a profession and with the power to give and to take away the privilege to practice.

II. PURPOSE

The purpose of this study is to explore the hypothesis that state legislatures would enhance patient safety and the quality of care by mandating that health professional licensing boards implement procedures requiring all health care professionals to demonstrate their continuing competence as a condition of relicensure.

The study addresses the following questions and makes recommendations related to many of them:

What current methodologies and techniques assess and document continuing professional competence?

Should licensees be permitted to demonstrate their continuing competence by a variety of approved methods and techniques, or should licensing boards specify a particular approach?

How frequently should licensees be required to demonstrate their competence?

Should all licensees be required to demonstrate their continuing competence periodically, or should this requirement apply only to those licensees whose performance causes the licensing board to question their competence?

How should state legislatures take into account the relationship between the continuing competence requirements of licensing boards and those of private specialty certification boards?

Should current board certification satisfy a licensing board that a licensee has again demonstrated his or her competence?

How should state legislatures address the relationships between licensing board continuing competence requirements and those of hospitals and other provider institutions?

Who should pay the costs of continuing competency assurance? Licensees? The state?

What should be the legal status of a licensee who cannot meet relicensure or recertification standards?

What rules of confidentiality, if any, should apply to this information?

What information should be given to the public concerning a health care provider's continuing competence?

III. METHODOLOGY

This study and the policy recommendations in it are anchored in CAC publications and projects related to continued professional competence over the past decade.

They are also based on the extensive expertise of the authors and a project advisory committee comprised of current or former CAC board members whose names appear in Appendix I.

That foundation is supplemented with:

- a review of the literature on assessing and assuring the continued competence of health professionals;
- a critical analysis of information provided by licensing boards and their national associations, accrediting agencies, and specialty certification boards, some of which is publicly available from Internet Web sites; and
- conversations with key stakeholders from interested communities, including professional associations, certifying agencies, specialty boards, licensing boards and their associations, hospital staff, researchers, consumer advocates, and testing organizations.

IV. FINDINGS

The principal finding of this study is that new laws are needed to require health professionals to demonstrate that they continue to be competent. Voluntary continuing competence or professional development programs have not done the job in the past and cannot be relied on to do so in the future. Even if they were to become more substantive and dependable, voluntary programs do not reach all members of a profession. Thus, a mandate is required, and the logical enforcers of that mandate are state professional licensing boards, the only entities poised to impose valid and reliable requirements for universal competency assessment and assurance

A new regulatory model is needed. A new regulatory model must go beyond imposing mandatory continuing education (CE) to require some form of the five-step model that includes periodic *assessment* of knowledge, skills, and clinical performance; development, execution, and documentation of an *improvement* plan based on the assessment; and periodic *demonstration* of current competence.

A) What current methodologies and techniques assess and document continuing professional competence?

A wide variety of methods and techniques has been used to evaluate and then document current professional competence in the United States and abroad. Among these methods are:

- written or oral examinations,
- peer review,
- consumer satisfaction surveys,
- records review,
- self-reflection leading to self-directed learning program portfolios,
- evaluation by "standardized patients,"
- on-site practice review,
- performance evaluations, and
- continuing education based on needs assessment and followed by a test or other verification that the course material has been absorbed.

Thus, one must first establish what is to be assessed and verified: Does reaffirming *entry-level* competence equate with demonstrating *current* competence? Or is it more appropriate to assess a professional's competence in the clinical setting or specialized area in which he or she practices? Is it important to assess core competency, cognitive knowledge, clinical performance, or a combination of these variables?

Both cognitive knowledge and clinical skills need to be assessed. There are psychometrically sound and legally defensible examinations for measuring *cognitive skills* for each licensed health profession; state boards now require applicants for initial licensure to perform acceptably on these examinations. Some professions have openly resisted objective assessment of *clinical performance*, and progress toward valid and reliable assessment has been difficult and expensive.

Are self-assessment and third-party assessment equivalent? A major policy issue for regulators is whether competency assessment must be delegated to independent third parties or self-assessment is sufficient. There is not enough evidence at this time to answer the question definitively. Many voluntary credentialing organizations and some regulatory agencies have adopted self-assessment as part of their emerging continuing competency or professional development programs. This approach is likely to be more acceptable to many professionals than is third-party assessment, as it appears to be a comparatively painless and potentially more cost-effective way to introduce periodic assessment into the routine of professional careers, at least until there is hard evidence that independent, third-party assessment is more reliable and valid.

A five-step competency assessment and demonstration model is most promising. After evaluating many of the existing competence-maintaining models, CAC recommended a five-step framework for assessing and demonstrating continuing professional competence:

1) Routine Periodic Assessment
2) Development of a Personal Improvement Plan
3) Implementation of the Improvement Plan
4) Documentation
5) Demonstration of Competence, based on steps 1 through 4 above

Steps 1 through 4 constitute *quality improvement*; step 5 is the *quality assurance* component, without which the process is incomplete. The critical first step is routine periodic assessment, the key to pinpointing knowledge deficiencies needing correction and to tailoring lifelong learning choices to the needs of individual health care professionals Assessment also reveals whether a practitioner *applies* his or her knowledge and skills competently in clinical situations.

B) Should licensees be permitted to demonstrate their continuing competence by a variety of approved methods and techniques, or should licensing boards specify a particular approach?

There is little convincing evidence that any one method or technique for demonstrating continuing competence is more valid and reliable than another, nor is there evidence clearly indicating that the use of any one method leads to better outcomes in patient safety or health care quality. However, what does not work is better documented, and there is continuing and widespread interest in finding a better way than traditional continuing education mandates to ensure continuing competence. It is precisely this current condition of uncertainty that provides a rich opportunity to test and compare a variety of techniques and creative innovations.

Among the questions pilot programs must answer are:

(1) what is the impact of continuing competency assurance on patient outcomes;

(2) is there value-added for practitioners and health care organizations that participate;

(3) what is the comparative reliability of various methodologies and techniques for assessing continuing competence; and

(4) on what bases should boards give deemed status to the competency assurance procedures of voluntary credentialing agencies, professional associations, employers, and other institutions.

C) How frequently should licensees be required to demonstrate their competence?

There is no basis as yet for determining how frequently health care practitioners should be required to demonstrate their continued competence. Licensing boards have varied time periods for license renewal, usually ranging from one to three years. Hospitals generally recredential their health care staff every two years.

A powerful rationale for requiring periodic demonstrations of continued competence is that health care technology, treatment protocols, practice guidelines, prescription medicines, medical devices, and other aspects of health care delivery change constantly. By demonstrating continued competence, health care professionals show that they have kept up with new developments related to their particular profession and specialty. The pace of change in health care delivery argues for a shorter time lag between demonstrations of competence, to the extent that such demonstrations are economically feasible.

D) Should all licensees be required to demonstrate their continuing competence periodically, or should this requirement apply only to those licensees whose performance causes the licensing board to question their competence?

A decade ago, there was considerable disagreement over whether all health care professionals should demonstrate their continuing competence periodically or only those whose competence has been called into question. The prevailing view is that continuing competency assessment and assurance should not be confined to "incompetent" practitioners or the few "bad apples." Rather, maintaining competence underpins any effort to assure patient safety and improve the quality of care, so it must apply to all practitioners.

E) How should state legislatures take into account the relationship between the continuing competence requirements of licensing boards and those of specialty certification boards? Should current board certification satisfy a licensing board that a licensee has again demonstrated his or her competence?

State legislatures need to provide guidance to licensing boards on implementing a continuing competency mandate. Within certain parameters, legislatures should empower boards to issue rules and regulations specifying acceptable *methods* for assessing and demonstrating competence. Legislatures should also empower boards to recognize a variety of acceptable *pathways* via which licensees can demonstrate their continuing competence. For example, boards might be authorized to recognize (deem) outside organizations as the board's *agents* in enforcing the new continuing competency requirements because few, if any, licensing boards have the resources to implement universal competency requirements. Moreover, such an effort by boards could unnecessarily duplicate sound assessment and demonstration programs already administered by other organizations. Legislatures and boards have to identify the criteria that outside organizations will be required to meet to earn deemed status. Several acceptable approaches are possible. Legislatures could choose to legislate some or all of the criteria that govern granting deemed status to private organizations; they could direct licensing boards to establish the deeming criteria by rules and regulations; or the legislature could establish criteria in broad policy terms and allow the boards to fill in the specifics. Whatever the approach, it is essential that any program for evaluating current competence be equivalent, in terms of public protection, to the program the licensing board establishes on its own for periodically evaluating and verifying the continued competence of its licensees.

F) How should state legislatures address the relationships between licensing board continuing competence requirements and those of hospitals and other provider institutions?

In addition to specialty certification bodies, licensing boards need to consider awarding deemed status to qualifying competency evaluation programs at hospitals and other institutions that credential, privilege, and/or employ health care professionals. An example of the kind of program that might satisfy board requirements is the third-party assessment program at Pitt County (North Carolina) Memorial Hospital, an academic medical center with 745 beds and 4,500 employees, including 1,200 nurses. This hospital revisited its employee orientation program in the wake of the IOM's Errors report and the Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) growing interest in ongoing competence and the nursing shortage. The hospital decided to administer to all new-hire nurses the performance-based development system (PBDS) created by Dr. Dorothy del Bueno of Performance Management Services Inc.

G) Who should pay the costs of recertification? Licensees? The state?

There are two types of costs associated with assessing and assuring continuing professional competence. First, there are the costs to health care professionals to assess and maintain their competence throughout their careers and to demonstrate periodically that they have done so. CAC has recommended that these costs should be borne by the licensed professionals.

The second category includes costs incurred by licensing boards in establishing and administering continuing competency requirements. There will be costs to establish the programs (including the cost of developing rules and regulations) and to administer them (preparing exams, evaluating "deemed status" applications, monitoring compliance). Each state will have to estimate expenditures and then decide whether to raise the funds by increasing licensing fees, seeking funding from general revenues, or some combination of both.

H) What should be the legal status of a licensee who cannot meet relicensure or recertification standards? What rules of confidentiality, if any, should apply to this information? What information should be given to the public concerning a health care provider's continuing competence?

Resolution of practitioner confidentiality issues may depend on whether the new continuing competency programs are considered:

(1) quality improvement/quality assurance under the boards' licensing responsibility (which is to issue licenses only to those who demonstrate minimal competence),

~ or ~

(2) part of the boards' disciplinary responsibility under which it removes or restricts the licenses of individuals who have violated the state practice act. In either case, the legal rationale for giving licensing boards responsibility in this area is the same—to protect and promote the public health and safety.

RECOMMENDATIONS

The agenda for reform presented in this study focuses on state government, since it is the states that license health care practitioners and, when necessary, discipline them. The authors propose the framework below for state legislative action, which forms the basis for the recommendations that follow:

- Eliminate continuing education requirements.
- Mandate that as a condition of relicensure, licensees participate in continuing professional development programs approved by their respective health care boards.
- Mandate that continuing professional development programs include
    a) assessment;
    b) development, execution, and documentation of a learning plan based on the assessment; and
    c) periodic demonstrations of continuing competence.
- Provide licensure boards with the flexibility to try different approaches to foster continued competence.
- Ensure that the boards' assessments of continuing competence address the knowledge, skills, attitudes, judgment, abilities, experience, and ethics necessary for safe and competent practice in the setting and role of an individual's practice at the time of relicensure.
- Require that boards evaluate their approaches to gathering evidence on the effectiveness of methods used for periodic assessment.
- Authorize licensure boards to grant deemed status to continuing competence programs administered by voluntary credentialing and specialty boards, or by hospitals and other health care delivery institutions, when the private programs meet board-established standards.

Significant challenges must be overcome to implement effective systems for continuing competency assessment and assurance. Progress is likely to be incremental and may be frustratingly slow. This is justification for moving expeditiously to enact the appropriate legislation and initiate pilot programs to generate the evidence on which to promulgate broad-based continuing competency programs that enhance patient safety and health care quality. To further that goal, we propose the following recommendations:

RECOMMENDATION 1:

State laws and implementing rules and regulations should require that, as a condition of relicensure, licensees participate in continuing professional development (CPD) programs approved by their respective boards. CPD programs must include

a) assessment;

b) development, execution, and documentation of a learning plan based on the assessment; and

c) periodic demonstrations of continuing competence.

Licensees should be permitted to demonstrate continuing competence through a variety of legally defensible, psychometrically sound, evidence-based methods.

RECOMMENDATION 2:

Demonstrations of continuing competence should cover the knowledge, skills, attitudes, judgment, abilities, experience, and ethics necessary for safe and competent practice in the setting and role of an individual's practice at the time of relicensure.

RECOMMENDATION 3:

State licensing boards should conduct pilots to test a variety of methods and techniques for periodic assessment and assurance of continued competence. The boards should designate an objective, third-party institution to assist in the design and evaluation of these programs.

RECOMMENDATION 4:

Professions should endeavor to codify standards and definitions of clinical competence that are relevant to them and incorporate those crosscutting competencies identified by the IOM as being relevant to all health care professions: patient-centered care, interdisciplinary teams, evidence-based practice, quality improvement, and informatics.

RECOMMENDATION 5:

Licensing boards should grant deemed status to continuing competence programs administered by voluntary credentialing and specialty boards, or by hospitals and other health care delivery institutions, when the private programs meet board-established standards. Boards must require organizations to meet or exceed the standards applicable to licensees who choose to demonstrate their continued competence through board-administered continuing competence programs.

RECOMMENDATION 6:

Licensees who choose to fulfill licensing board continuing competence requirements by meeting the parallel requirements of a certifying body, employer, professional association, or other organization to which the board has given deemed status, shall waive the deemed organization's confidentiality provisions to give the board access to information pertinent to competency assessment and demonstration.

RECOMMENDATION 7:

Licensees should bear the costs of assessing and demonstrating their continuing competence, either individually or though private sources of funding, such as professional associations, insurance carriers, employers, and the like.

RECOMMENDATION 8:

The board should inform the public whether a licensee has been successful in demonstrating his or her continuing competence.

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