News & Views

Citizen Advocacy Center

First Quarter, 2007 A Health Care Public Policy Forum Volume 19 Number 1

MARK YOUR CALENDARS

October 29-31, 2007 – Seattle, Washington

CITIZEN ADVOCACY CENTER 2007 ANNUAL MEETING

CAC's 2007 Annual Meeting will be co-sponsored by the Washington State Department of Health. It will be held Monday, Tuesday, and Wednesday, October 29-31, 2007, at the Edgewater Hotel in Seattle, Washington. CAC meetings are open, and all interested parties are welcome. Look for agenda and registration materials in the late spring.

Notice: This issue of CAC News & Views is the first issue that is available for download from our website. When viewed onscreen in PDF format, the Table of Contents includes links to all of the articles.

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Editorial Note: ***In this issue, we report on several cases where state licensing boards have taken actions that appear to be primarily "economic" regulations rather than regulation designed to protect public health and safety. (See, for example, "Medical Board Tries to Tie Hands of Physical Therapy Board" and "Horror Case of the Quarter.")***

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Since its inception, CAC has contended that one key role public members should assume is that of "watchdog." This role includes a responsibility to question and vigorously oppose regulations – such as business restrictions - that do not qualify as protecting the public health and safety.

This issue also contains articles about boards that have proposed regulations that appear to thwart an expanded scope of practice regulation passed by the legislature. (See, for example, "Georgia Struggles to Implement Prescriptive Authority for Nurses" and "North Carolina Paper Gives Rare Glimpse into the Politics of Scope of Practice Decisions.") CAC calls on public members to question and oppose any such actions that cannot be demonstrated to support public health and safety. As the cases we report indicate, the need continues for public members to play a watchdog role.

SCOPE OF PRACTICE

Licensing Board Associations Produce Legislative Guide to Scope of Practice Changes

Six associations of regulatory boards have joined together to write a document entitled, ***Changes in Healthcare Professions' Scope of Practice: Legislative Considerations***, to assist legislators, regulatory boards, and the health care professions assess proposed changes in health professions scope of practice. The collaborators on the document are the Association of Social Work Boards (ASWB), the Federation of State Boards of Physical Therapy (FSBPT), the Federation of State Medical Boards (FSMB), the National Association of Boards of Pharmacy (NABP), the National Board for Certification in Occupational Therapy (NBCOT), and the National Council of State

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Boards of Nursing (NCSBN). Although not stated in so many words, this document can be considered a response to the American Medical Association's aggressive efforts in recent years to obstruct legislation aimed at expanding the scopes of "non-doctor" health care professions.

Editorial Note: CAC applauds the Federation of State Medical Boards for participating in this document.

What follows are excerpts from this important document. The complete text is online at ***https://www.ncsbn.org/ScopeofPractice.pdf.***

I. Executive Summary

> …. Proposed changes to a healthcare profession's scope of practice often elicit strongly worded comments from several professional interest groups. Typically, these debates are perceived as turf battles between two or more professions, with the common refrain of "this is part of my practice so it can't be part of yours." Often lost among the competing arguments and assertions are the most important issues of whether this proposed change will better protect the public and enhance consumers' access to competent healthcare services.
>
> …. It is no longer reasonable to expect each profession to have a completely unique scope of practice, exclusive of all others. We believe that scope of practice changes should reflect the evolution of abilities of each healthcare discipline, and we therefore have attempted to develop a rational and useful way to make decisions when considering practice act changes. Based on reports from the Institute of Medicine and the Pew Health Professions Commission, we propose a process for addressing scope of practice, which is focused on patient safety. The question that healthcare professionals must answer today is whether their profession can provide this proposed service in a safe and effective manner. If an issue does not address this question, it has no relevance to the discussion….

II. Changes in Healthcare Professions Scope of Practice: Legislative Considerations

A. Purpose

The purpose of this document is to provide information and guidance for legislative and regulatory agency decision making regarding changes in the scope of practice of healthcare professions.

Specifically, the purpose is to:

- Promote better consumer care across professions and competent providers
- Improve access to care
- Recognize the inevitability of overlapping scopes of practice….

B. Background

This paper … attempts to address scope of practice issues from a public protection viewpoint by determining whether a specific healthcare profession is capable of providing the proposed care in a safe and effective manner.

We believe that it is critical to review scope of practice issues broadly if our regulatory system is going to achieve the recommendations made by both the Institute of Medicine and the Pew Health Professions Commission Taskforce on Healthcare Workforce Regulation. These reports urge legislators to allow for innovation in the use of all types of clinicians in meeting consumer needs in the most effective and efficient way, and to explore pathways to allow all professionals to provide services to the full extent of their current knowledge, training, experience, and skills….

C. Introduction

The scope of practice of a licensed healthcare profession is statutorily defined in each state's laws in the form of a practice act. State legislatures have the authority to adopt or modify practice acts and therefore adopt or modify a particular scope of practice of a healthcare profession. Sometimes such modifications of practice acts are just the formalization of changes already occurring in education or practice within a profession, due to the results of research, advances in technology, and changes in societal healthcare demands, among other things.

The process sometimes pits one profession against another before the state legislature. As an example, one profession may perceive another profession as "encroaching" into their area of practice. The profession may be economically or otherwise threatened and therefore opposes the other profession's legislative effort to change scope of practice. Proposed changes in scopes of practice that are supported by one profession but opposed by other professions may be perceived by legislators and the public as "turf battles." These turf battles are often costly and time consuming for regulatory bodies, the professions, and the legislators involved. Aside from guidance on scope of practice issues, this document may assist in preventing costly legislative battles; promote better consumer care and collaboration among regulatory bodies, the professions and between competent providers; and improve access to care.

III. The Purpose of Regulation

…. According to Schmitt and Shimberg, regulation is intended to:

1) "Ensure that the public is protected from unscrupulous, incompetent and unethical practitioners;"

2) "Offer some assurance to the public that the regulated individual is competent to provide certain services in a safe and effective manner;" and

3) "Provide a means by which individuals who fail to comply with the profession's standards can be disciplined, including the revocation of their licenses."

A. Defining Scope of Practice

The 1995 Report of the Pew Health Professions Commission Task Force on Healthcare Workforce Regulation defined scope of practice as the "definition of the rules, the regulations, and the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience may practice in a field of medicine or surgery, or other specifically defined field. Such practice is also governed by requirements for continuing education and professional accountability."

B. Assumptions Related to Scope of Practice

In attempting to provide a framework for scope of practice decisions, basic assumptions can be made:

1) The purpose of regulation – public protection – should have top priority in scope of practice decisions, rather than professional self-interest….

2) Changes in scope of practice are inherent in our current healthcare system….

3) Collaboration between healthcare providers should be the professional norm….

4) Overlap among professions is necessary….

5) Practice acts should require licensees to demonstrate that they have the requisite training and competence to provide a service….

In addition, all healthcare providers' scopes of practice include advanced skills that are not learned in entry-level education programs, and would not be appropriate for an entry-level practitioner to perform. As professions evolve, new techniques are developed; not all practitioners are competent to perform these new techniques.

IV. The Basis for Decisions Related to Changes in Scope of Practice

Arguments for scope of practice changes should have a foundational basis in four areas:

1) an established history of the practice scope within the profession

2) education and training

3) supportive evidence, and

4) appropriate regulatory environment

A. Historical Basis

…. Changes in statutory scope of practice should fit within the historical, evolutionary and present practice context for the profession.

Questions to be considered in this area include:

1) *Has there been an evolution of the profession towards the addition of the new skill or service?*

2) *What is the evidence of this evolution?*

3) *How does the new skill or service fit within or enhance a current area of expertise?*

B. Education and Training

Tasks added to scopes of practice are often initially performed by professionals as advanced skills. Over time, as these new skills and techniques are utilized by a sufficient cohort of practitioners, they become entry-level skills and are taught as such in entry-level curricula. It is not realistic to require a skill or activity to be taught in an entry-level program before it becomes part of a profession's scope of practice. If this were the standard, there would be few, if any, increases in scope of practice. However, the entry-level training program and its accompanying accrediting standards should provide the framework, including the basic knowledge and skills needed, to acquire the new skill once out in the field. There should be appropriate accredited post-professional training programs and competence assessment tools that indicate whether the practitioner is competent to perform the advanced skill safely.

Questions to be considered in this area include:

1) *Does current entry-level education prepare practitioners to perform this skill as their experience increases?*

2) *If the change in scope is an advanced skill that would not be tested on the entry-level licensure examination, how is competence in the new technique assured?*

3) *What competence measures are available and what is the validity of these measures?*

4) *Are there training programs within the profession for obtaining the new skill or technique?*

5) *Are standards and criteria established for these programs?*

6) *Who develops these standards?*

7) *How and by whom are these programs evaluated against these standards?*

C. Evidence

There should be evidence that the new skill or technique, as used by these practitioners, will promote access to quality healthcare. The base of evidence should include the best available clinical evidence, clinical expertise and research. Other forms of evidence include evolving concepts of disease / disability management, quality improvement and risk data, standards of care, infection control data, cost-effectiveness analysis and benchmarking data. Available evidence should be presented in an easy-to-understand format and in an objective and transparent manner.

Questions to be considered in this area include:

1) *Is there evidence within the profession related to the particular procedures and skills involved in the changes in scope?*

2) *Is there evidence that the procedure or skill is beneficial to public health?*

D. Regulatory Environment

…. Often, it is the professional association that promotes and lobbies for scope of practice changes. The regulatory board should be involved in the process and be prepared to deal with the regulatory issues related to the proposed changes.

Questions to be considered in this area include:

1) *Is the regulatory board authorized to develop rules related to a changed or expanded scope?*

2) *Is the board able to determine the assessment mechanisms for determining if an individual professional is competent to perform the task?*

3) *Is the board able to determine the standards that training programs should be based on?*

4) *Does the board have sufficient authority to discipline any practitioner who performs the task or skill incorrectly or might likely harm a patient?*

5) *Have standards of practice been developed for the new task or skill?*

6) *How has the education, training and assessment within the profession expanded to include the knowledge base, skill set and judgments required to perform the tasks and skills?*

7) *What measures will be in place to assure competence?*

V. Basis for Legislative Decision Making

Although the areas for decision making listed above do not specifically mention public protection, supplying documentation in historical basis, education and training, evidence, and the regulatory environment is likely to ensure that the public will be protected when these changes are made.

Potential for harm to the consumer is difficult to prove or disprove relative to scope of practice. It is the very fact that there is potential for harm that necessitates regulation. If a strong basis for the redefined scope is demonstrated as described above, this basis will be rooted in public protection.

This paper rests on the premise that the only factors relevant to scope of practice decision making are those designed to ensure that all licensed practitioners be capable of providing competent care….

Pennsylvania Governor Advocates Expanded Use of Nurse Practitioners

On January 17, 2007, Governor Ed Rendell of Pennsylvania unveiled a "Prescription for Pennsylvania" intended to increase affordable health care coverage for all Pennsylvanians, improve the quality of care, and bring health care costs under control. A significant part of the proposal would improve access to care and cut costs by adjusting the regulatory environment so as to allow nurses, advanced nurse practitioners, midwives, physician assistants, pharmacists, dental hygienists and other licensed health care providers to practice to the fullest extent of their training and skills.

At a press briefing the previous December, Governor Rendell gave reporters a sense of what he intends by this proposal. The following are excerpts from his remarks as reported online by Capitolwire.com news service:

> Well, I'll give you one example. For example, we should employ nurse practitioners in the delivery of health care services far more than we do.
>
> It's estimated by academics that a nurse practitioner can perform about 70 percent of the things that a primary care physician can do, as well as 80 percent of what a pediatric primary care physician can do. And they do them for often 50 percent or less of the costs.
>
> So why don't we do that in Pennsylvania? Because the things that nurse practitioners can do are often limited by regulation or statute.
>
> I want to free nurse practitioners to virtually do anything they are capable of doing. Unlock all of those regulations, all the restrictions, and put them back into the game.

I don't know if many of you followed it, but I did a press conference at a Walgreens in Beaver County, where a private company is putting in these big-box Walgreens, a nurse practitioner clinic where citizens can go in and get non-emergency care.

Often the same care that citizens go to emergency rooms to get, because they don't have a primary care physician or they can't afford it, etc., and even if they're Medicaid [recipients], a nurse practitioner can give them an inoculation, a flu shot, well that's again 50 percent of the cost of going to a doctor for a flu shot.

So we ought to be doing that.

In every emergency room in the state, we ought to have a second room for non-emergency care.

I always give the example: you're playing with your dog and your dog accidentally bites you on the webbing of your hand. You're bleeding and you can't stop the bleeding. If it happens at 10 at night or two o'clock in the morning, you have to go to an emergency room. You go to an emergency room and it's busy, they'll give you a piece of gauze and say, "Keep the pressure on," and maybe they'll see you four-and-a-half hours later.

Why?

Why not have a second room, staffed with nurse practitioners who look at that, put mercurochrome on it and stitch you up – at 40 percent of the cost of getting a doctor into an emergency room to do it?

Why can't we do that?

One, there are none of those rooms available. But, two, nurses cannot give stitches, cannot do stitches in Pennsylvania outside the presence of a doctor.

They can do it if a doctor's in the room, but they can't do it outside the presence of a doctor.

Why?

Mark A. Piasio, MD, MBA, president of the Pennsylvania Medical Society and a practicing orthopedic surgeon from DuBois, Pennsylvania, issued the following statement in reaction to the Governor's December 11 remarks:

> Recently, Governor Rendell made brief comments on future plans to reduce health care costs by expanding the scope of practice of nurse practitioners. The Pennsylvania Medical Society will carefully review the Governor's plan once the details are made public in January.

Physicians now work in collaborative teams with nurse practitioners, physician assistants and other caregivers. Allied health practitioners can help with problems of access, but there needs to be appropriate accountability and supervision.

The Pennsylvania Medical Society supports the appropriate use of allied health practitioners as part of collaborative health care teams, including nurse practitioners. Quality of care and patient safety are paramount.

The Medical Society encourages the collection and analysis of additional data to support the contention that expanded scope of practice will reduce overall costs. A full study should include the financial impact that use of practitioners will have on utilization and frequency.

Overall, efforts must be made to safeguard against further fragmentation of health services and breakdown in coordination of medical care.

Georgia Struggles to Implement Prescriptive Authority for Nurses

Having failed in September, 2006 to force a repeal of a new law giving advanced practice nurses (APN) limited prescriptive authority, the Medical Association of Georgia put pressure on the state's medical board to draft restrictive implementation rules giving supervising physicians excessively tight control over APNs. Rules passed by the medical board in December 2006 call for a physician to audit all prescription records of the APNs under their supervision. Nurses contend the burdensome rules conflict with the spirit of the legislation and undermine any positive impact the legislation would have on access to care.

The skirmishing returned to the legislature in 2007. In February, advanced practice nurses filed a resolution in the state General Assembly asking legislators to urge the medical board to draft new implementing rules that conform to the spirit of the prescriptive practice law.

Later in the month, a state Senate committee declined to pass a bill that would have amended the original law so as to include the restrictions favored by the medical society. The bill was co-sponsored by State Senator, Don Thomas, the body's only physician and chairman of the Senate Health and Human Services Committee. Responding to objections by nurses and some committee members, Thomas referred the draft language back to a subcommittee for more work. The controversial sections (Feb 28, 2007 version) include the following:

> (6) Provide for <u>on-site</u> patient ~~evaluation or follow-up~~ examination by the delegating physician or other physician designated by the delegating physician pursuant to paragraph (2) of this subsection, with the

frequency of such ~~evaluation or follow-up~~ examination based on the nature, extent, and scope of the delegated act or acts as determined by the delegating physician in accordance with paragraph (3) of this subsection and accepted standards of medical practice as determined by the board;
(7) Be reviewed, revised, or updated annually by the delegating physician and the advanced practice registered nurse;
(8) Be available for review upon written request to the advanced practice registered nurse by the Georgia Board of Nursing or to the physician by the board; and
(9) Provide that ~~a patient who receives~~ 100 percent of all patients who receive a prescription drug order for any controlled substance pursuant to a nurse protocol agreement shall be ~~evaluated or~~ examined on-site by the delegating physician or other physician designated by the delegating physician pursuant to paragraph (2) of this subsection on at least a quarterly basis ~~or at a more frequent interval as determined by the board~~; provided, however, that this paragraph shall not apply to a patient who has received a prescription drug order for a ten-day or less supply of a controlled substance during the quarter."
"(m) The board shall have the authority to promulgate rules and regulations governing a delegating physician in order to carry out the intents and purposes of this Code section. Further, the board shall be authorized to:
(1) Require that a nurse protocol agreement and registration form shall be filed by the delegating physician with the board for approval and shall be accompanied by the required fee, which shall not be refundable, within a reasonable time from the date of execution;
(2) Determine, after review of a filed nurse protocol agreement, if such nurse protocol agreement fails to meet accepted standards of medical practice as established by the board; and (3) Require the delegating physician to amend any such noncompliant nurse protocol agreement in order to meet such accepted standards.
(n) Except for practice settings identified in paragraph (7) of subsection (g) of this Code section, it shall be unlawful for a physician to be ~~an employee~~ employed by or a consultant of an advanced practice registered nurse, alone or in combination with others, if the physician is required to supervise the employing advanced practice registered nurse. Such conduct shall be subject to sanctions by the Georgia Board of Nursing as to the advanced practice registered nurse and the board as to the physician."

In the meantime, the medical board voted on March 2 to table a fourth iteration of implementing rules, leaving a more restrictive version in effect.

Medical Board Tries to Tie Hands of Physical Therapy Board

Legislation introduced by the medical establishment in Alabama would prohibit the physical therapy board from promulgating any rule related to physical

therapists (PTs) working for physicians. The proposed bill is a reaction to an attempt by the Board of Physical Therapy to pass a rule prohibiting PTs from working for physicians.

First read on March 13, 2007, the proposed amendment to the Code of Alabama would prohibit the Board of Physical Therapy from "promulgating any rule relating to licensure denial, suspension, or revocation, or from taking any disciplinary action against a licensee by virtue of certain employment arrangements, contractual agreements, or referrals by physicians."

Editorial Note: CAC News & Views considers this a classic case of "two wrongs don't make a right." In our view, it was inappropriate for the PT Board to attempt to interject itself in its licensees' business arrangements – unless questions of public health and safety were involved, which does not appear to be the case here. Second, it is inappropriate for the physician community to try to prohibit another profession's board from rulemaking.

New Mexico Poised to Restore Optometry Scope of Practice

A modification in Medicare reimbursement policies categorizes minor eye care procedures as "surgeries," thus eliminating them from the scope of practice of New Mexico's optometrists. The state's optometrists performed procedures, such as removing eye tags from eyelids, for decades before the Medicare reimbursement codes were changed to call these surgical procedures. Legislation that would restore optometrists' ability to provide these services has been approved by both houses of the state legislature.

The New Mexico Academy of Ophthalmology fought the legislation, claiming that optometrists are unqualified to use sharp objects around patients' eyes. They went so far as to produce broadcast ads comparing optometrists to butchers because their initial training in the use of scalpels is on cadavers and meat. Optometrists do practice on live patients before graduating from optometry school.

North Carolina Paper Gives Rare Glimpse into the Politics of Scope of Practice Decisions

Dan Kane, staff writer for the Raleigh, North Carolina ***News & Observer*** wrote on September 2, 2006 about convoluted political intrigue over more than five years that gave the state medical board more powers and higher fees in return for giving optometrists an expanded scope of practice.

Kane's article, entitled "Political Deal Let Optometrists Do Eye Injections, Records Show," documents negotiations in June, 2000 between Andrew Watry, then-executive director of the North Carolina Medical Board and the state's Optometry Board (with the knowledge of the House Speaker, Jim Black, an optometrist) over a consent agreement that would have given optometrists authority to administer five types of eye injections in order to get support for medical board-sponsored legislation. The deal fell through, reports Kane, when the medical board legislation failed to pass both houses of the legislature.

The optometry board wasn't ready to let the agreement slide, however, and sued the medical board in November 2003. The boards negotiated a deal in 2005 that allowed for a partial expansion of the optometry scope of practice. Spokespersons

for the state ophthalmology society told Kane they believe Speaker Black's exertion of political pressure on the medical board resulted in permitting optometrists to perform procedures that ophthalmologists feel better qualified to safely perform. Watry told Kane he believes the ophthalmologists were more worried about losing lucrative business than they were about quality of care.

Editorial Note: CANews concludes that this tangled story underscores the importance of finding a process for making scope of practice decisions based on medical evidence and the public interest (the greatest good for the greatest number) rather than political influence or quid pro quo deal making. It may well be that the optometrists' expanded scope of practice improves patient access to care without compromising safety, but the process by which the North Carolina regulatory boards and legislature got to that point leaves a lot to be desired. (See the first item in the SCOPE OF PRACTICE section.)

U.S. Congressman Wants FTC to Investigate Practitioner Claims

U.S. Representative John Sullivan (R-OK) introduced legislation that would involve the Federal Trade Commission (FTC) in investigating allegations that health care practitioners are passing themselves off as doctors. Sullivan contends that changes in state law blur the distinction between physicians and other practitioners, causing consumers to be confused about the qualifications of those who treat them.

The legislation is supported by the American Medical Association (AMA) and other members of the Coalition for Healthcare Accountability, Responsibility and Transparency, which is battling enhanced scopes of practice for "non-M.D. practitioners" across the country. AMA Board member, Dr. Rebecca Patchin, told the Jim Meyers of the ***Tulsa World*** that a national survey found a majority of respondents believe podiatrists, optometrists, psychologists and chiropractors are medical doctors. She said one third of those surveyed thought a dental assistant is a medical doctor.

Opposing the bill, David Cockrell, vice president of the Oklahoma State Board of Examiners in Optometry pointed out that all 50 states have laws prohibiting people from falsely representing themselves as physicians. Seventy percent of patients, he claims, receive their eye care from optometrists.

Lay Midwife Fights for Right to Practice in Pennsylvania

Editorial Note: Given the sizeable Amish population in Pennsylvania, the implementation of Governor Rendell's "Prescription for Pennsylvania" (see story earlier in this section) may include reconciling the regulatory distinction between licensed nurse midwives and certified lay midwives.

A brief disciplinary hearing before the Pennsylvania Board of Medicine on January 27, 2007 caused about 300 Amish and Mennonite residents to rally in support of Diane Goslin, a lay midwife accused of practicing medicine and midwifery without a state license. Goslin concedes that she does not have the academic degree or the RN license required by Pennsylvania to obtain a nurse midwife license. She does,

however, claim to be qualified to practice, based on 25 years of experience as a lay midwife and her certification to practice from the North American Registry of Midwives (a credential which is recognized in 28 other states). Goslin also disputes the charge against her, which is that she "delivered" a child in 2005. She admits she was "present" at the birth, but did not "deliver" the child.

Demonstrators at the rally said it is they who would be punished if Goslin and other lay midwives are put out of business. Lay midwives do home births, something that is important to Amish and Mennonite families who do not have transportation. Also, their services are less expensive than those of a licensed midwife or a hospital.

Canadian Pharmacists Given Prescriptive Authority

After April 1, 2007, pharmacists in Alberta, Canada will have limited prescriptive authority. They will be permitted to refill existing prescriptions and provide emergency supplies of previously prescribed medicines. Pharmacists will not be able to prescribe narcotics or steroids, but those who can demonstrate the needed qualifications will be able to prescribe medications for chronic illnesses and to administer injections. Rules to implement the new regulation are expected by the end of this year.

The Canadian Medical Association (CMA) opposes the expanded scope of practice for pharmacists, raising the familiar arguments that pharmacists are not trained to diagnose and that there is a potential conflict of interest given that pharmacists sell the medications they would be prescribing. The Canadian Pharmacists Association is prepared to assist pharmacists in adapting to the new scope of practice.

ADMINISTRATION

Nevada Board Found in Violation of Law

The Nevada Board of Homeopathic Medical Examiners was found by a Legislative Commission auditor to be guilty of violating the state's open meetings law and of making inappropriate expenditures. The auditors concluded that many of the violations were caused by ignorance of state requirements. The open meetings law was violated because the board did not have a good process for writing and approving meeting minutes. The improper expenditures included payments that were inaccurate, were not approved, or were for expenses not related to board business. An expenditure of $5,500 to a former board president was for legislative lobbying. This sum represented 20% of the board's revenue for the year. The board was delinquent to the tune of $83,500 in paying the Attorney General's office for legal services.

LICENSURE

Nurses Promote Licensure Portability

The National Council of State Boards of Nursing (NCSBN) convened a Licensure Portability Summit in December 2006 to inform boards of nursing how to implement two NCSBN programs, the Nurse Licensure Compact (NLC) and Criminal Background Checks (CBC). Funded by a grant from the Health Resources and Services

Administration's Office for the Advancement of Telehealth, the summit was attended by representatives from more than 25 boards of nursing that have not adopted either NLC or CBC.

The NLC is modeled after the U.S. Drivers License Compact and allows nurses who reside in an NLC state and meet the uniform core requirements to practice in other participating NLC states. The NCSBN National Assembly adopted CBCs (especially FBI fingerprint checks) as one of the core requirements for state boards of nursing.

The grant is for the purpose of reducing licensure portability barriers for nurses. It focuses on areas needing study, such as potential start-up costs, reasons for opposing NLC and / or CBC, and potential policy models for making CBC portable from state to state

Court Suspends Licensure Requirement for Expert Witnesses

The supreme court of South Carolina temporarily suspended a new law requiring out-of-state doctors to obtain a temporary South Carolina license in order to testify as expert witnesses. The Beaufort County prosecutor said the law could disrupt a number of his cases because people seriously injured in crimes are often taken to a hospital in nearby Georgia which has the closest trauma center. He wants the law rescinded.

Speaking for the Board of Medical Examiners, vice president Louie Costa MD told the Columbia South Carolina ***State*** that the law is intended to make expert witnesses accountable. There had been a recent incident in which an out-of-state physician delivered malicious testimony, but the board could do nothing about it.

Editorial Note: Mississippi chose to deal with expert witnesses in a regulation requiring them to abide by ethical standards that prohibit false, fraudulent or forged statements or documents. In-state violators could lose their Mississippi licenses. Out-of-state violators could be reported to their boards and / or be prohibited from testifying again in Mississippi. Legislation that would have regulated expert witnesses in Missouri failed to make it out of committee in the 2006 General Assembly session.

Court Rules Medicinal Marijuana Law Applies Only to State's Licensees

The Washington State Supreme Court decided in November, 2006 to uphold the conviction of a Washington resident for possession of marijuana because the medical authorization was signed by a physician licensed in California, not Washington State. A voter initiative (I692) approved in 1998 gives doctors the right to recommend marijuana to patients, but not to prescribe it. The law is silent about how patients are expected to obtain the substance. The patient in question obtained a California medical marijuana card because she had been spending a lot of time there caring for her mother.

The defense attorney questioned the difference between obtaining a prescription pain medication from a doctor licensed in California and obtaining medical marijuana from the same doctor. The author of the three-judge dissenting opinion wrote that the

"majority decision deprives Sharon Tracy of the protections afforded by the people through this legislation, and allows her to be convicted of a crime for exercising that privilege."

IN-DEPTH

BEN SHIMBERG MEMORIAL LECTURE – Delivered by John Rother, 2006 Recipient of the Ben Shimberg Public Service Award Williamsburg, Virginia, October 19, 2006

It is a great honor to receive an award named for Ben Shimberg. I recognize I am joining terrific company in Mark Yessian and Julie Fellmeth, and I thank them for being here tonight.

I didn't know Ben directly, but I know enough about him to recognize that he set a high standard. I can't think of anyone who better personifies a citizen advocate. Ben was an AARP volunteer, so we do have that connection. He was one of the first people to volunteer to serve as a beneficiary representative in what was one of the first attempts at a quality improvement device then called the PRO program, preceding the QIO program of today. It was partly due to Ben's experiences that AARP focused on the need for public representation on licensure boards throughout the country. Ben was a model for AARP's activism in promoting health quality, and it is because of his leadership and his inspiration that we are here tonight. I am proud to try to live up to that example.

It is also fun to be here with Dave and Becky because they do such good work. Because CAC grew out of something we started at AARP, I think it is appropriate that AARP support it in every way we can. With our volunteers in Virginia, we may be starting another round of innovation in how to be more effective citizen advocates in the cause of health quality.

Being in Williamsburg makes me think a bit about the history of medical care. I don't know if you have read much medical history, but you should probably know that before about 1900, it was a close call as to whether medicine was really legitimate or not. There is a quote I want to share with you from Oliver Wendell Holmes. It was his opinion that anyone who claims to be a doctor and practice orthodox medical care should be thrown into the sea, which he said, "would be all the better for mankind and all the worse for the fishes." There is some truth to that, because doctors at that time employed unappealing techniques, including the use of leeches. Modern medicine is a more recent profession than many realize.

I recently read a terrific book about the great flu pandemic during World War I. That was the first time the United States was forced to take seriously the whole issue of public health and the medical profession had to take seriously the need to respond adequately to an ongoing pandemic. Millions of people died – over 10% of the population in some cities.

Medical care today is a completely different enterprise than it was before that time. It was obvious at that point that doctors had not been well-trained, that the system we had was not responsive, and that we needed to so something serious – something big – to raise the level of medical care in the United States.

Before the time of the flu pandemic, doctors could declare they were a doctor without much training. There were medical schools, but they were basically run for profit. There were no national standards and little evidence that sick people were better off for having seen a doctor.

We have changed a lot in the past 100 years or so. And, now we are going through another kind of revolution in health care. It is a revolution of accountability and transparency, and it may have the same potential to raise the bar in the same way that requiring doctors to be science-based in their medical training did a century ago.

This new revolution is about measurement. It is about being accountable. It is about being committed to quality improvement on an ongoing basis. Of course, you are part of that. I have been privileged to be involved with all kinds of organizations that are interested and committed to raising the bar in health care. There is some very good work going on right now – and your work is part of the bigger picture.

For example, the American Board of Internal Medicine (ABIM) is a leader in realizing that just because someone was board-certified when he or she first entered practice does not mean they are up-to-date on everything today. Now, ABIM is requiring periodic recertification. This is important for consumers, not only because it will encourage doctors to stay current with innovations in medical care, it is important because part of the recertification asks doctors to survey their patients and listen to their feedback.

What a concept! Patients actually might have something to say about health care quality.

How did doctors react to this? They resisted. This was a big fight. At AARP, we have what is called 360 feedback from our co-workers on a regular basis. It is a high-risk enterprise because the feedback is anonymous. That is what we are asking physicians to do now as part of their recertification. It turns out that in the course of getting patient feedback, doctors discovered serious problems with patient-physician communication of which they previously had been unaware.

Many patients have a lot of anxiety about seeing doctors. Doctors are often pressed for time. Usually, what happens is that the patient reports a problem and the doctor says, “Yeah, I know what that is, take this and good bye.” Well, the patient may have had other things to talk about, but never got to them.

We behave as if all patients have photographic memories and recall everything the doctor says they should do. But, all the evidence is that the moment he or she walks out of the office, the average patient has forgotten about half of what the doctor said. Do you think there is a need to follow up a day or two later to ask the patient if she remembered to do this or that? Doctors are discovering that this is necessary to good quality care. There has to be follow-up and better compliance by patients. Doctors discover things when they do the follow up. The patient may say, “By the way, I have this other problem...”

Patient communication turns out to be central to improving quality. But good communication wasn’t happening on its own. It is beginning to happen only as a result of the 360 feedback requirement as a condition of being recertified. The doctors that resisted are now saying they are learning from this and it is a good thing.

Being transparent and accountable is important to one's peers and to the whole idea of serving patients. Patients have an equal responsibility to participate in a process of communication and therapy that can lead to better outcomes.

I think we are learning more about how to measure health care and how to set standards for evidence-based good practices. The whole field of medicine is moving much more aggressively from art (although art always will be involved) to science with a real foundation.

Still, there remain real variations in quality depending on what part of the country you are in, what hospital you go to, what physician you see. We know from our own data that people are not aware that these variations in quality exist. People today hold three erroneous assumptions about health care quality:

1. *"If I pick a good doctor, I don't have to worry about anything else because he or she will watch out for me and take care of me and that is all that matters."*

Picking a good doctor is important, but a good doctor in a bad system cannot deliver good health care.

2. *"Health care generally is pretty good, and if state licensing boards do their job and get rid of the few bad apples, I'm okay."*

There are bad apples, and it is important to remove them, but is that enough to ensure that people get optimum health care? Most people in the field would say no because there remain huge variations in quality depending on the region in which you live. So, it can't just be about the bad apples.

3. *"My ultimate protection if something bad happens is to go to court and sue for malpractice."*

In fact, very few people who are injured go to court and very few of those who do file suit receive an award in a timely fashion, even when it is obvious they were injured by malpractice. Very few doctors have any incentive as a result of this system to improve practice. In fact, the incentive is to cover it up rather than share information about errors to help the system improve. So, the current malpractice system, in my view, is giving false assurance to the public that it is ensuring quality. Actually, it is doing the opposite; it is making it harder to improve quality by making it more difficult for doctors to report problems and deal with them.

In other industries the emphasis is on reporting errors right away and looking at system changes to deal with them. As the Institution of Medicine observed, we will never have perfect doctors, so we need systems to catch errors before they occur. An example is electronic prescriptions. Why, in the twenty-first century, are we still relying on hand-writing? A news report earlier this week said that about 700,000 people are victims each year of mistakes in hospitals due to errors in prescriptions.

Earlier, the Institute of Medicine said that up to 100,000 people die in hospitals each year from preventable errors, many of which are medication-based. If we can correct this, we really will be seeing the next revolution in health care.

As much as quality improvement is on our minds, ultimately, we can't have a quality health care system unless we take on other issues, such as universal coverage, affordability, training, and so on. There is a lot wrong with our health care system and just making sure that the licensure part works is great, but it is not sufficient. Just making sure that doctors are recertified in a comprehensive way every ten years or so is great, but it is not sufficient. Making sure we publicly report the outcomes of various procedures so we can compare one hospital to another, and maybe one doctor to another, is great, but that is not sufficient either.

These are all changes that AARP believes are necessary. However, I think we are coming to a point in the United States where even bigger changes should be happening. Maybe some of you also have reached the conclusion that the health care system we have today is broken. The people I hear say that most often are physicians, nurses and others who are in the system every day. They say it's just not working and they can't make it work.

What are they talking about? They really are talking about the insurance claims system. We have created so many barriers to people doing the right thing that they feel as if they are being smothered. The financial incentives we have created also drive a lot of behaviors. Under fee-for-service, the financial incentive is to do more and more, so that is what we are getting. We're not necessarily getting better and better. We are not necessarily getting resources directed where they can do the most good.

So, it is time to think about making a run at broader-scale changes in our health system. This is an idea that originated with Teddy Roosevelt. Many presidents since that time have made proposals for health reform. FDR, Truman, Eisenhower, Nixon, Johnson, and, more recently, the Clintons did. Even both Bushes offered what they called "health reform initiatives." Each one was different and each one either failed or was only partially successful.

Health care is such a dynamic field, I don't think there is any possibility we will have a permanent answer or solution. But, we can certainly do better than we are doing today. I think it is time for the American people and those involved in the professions to demand change.

At AARP, we have very ambitious hopes that in the next two years, leading into the 2008 presidential election, we can make health reform the leading domestic issue, forcing candidates to address the topic and to make serious proposals. That doesn't guarantee action, but if the public makes clear that the health care system needs change, and if every presidential candidate commits to it, that mandate should lead to something after the new president takes office.

It is important to be clear about what we want. Yet, it is *most* important to engage in the political system and to change public attitudes so that we get past this idea that we are all in it for ourselves alone, and that—with consumer-driven health care—we can all fix our own problems. We need to see this as a system that needs to be strengthened. It's not just Medicare, or Medicaid, or medical education—it's the whole thing.

How are we going to change public attitudes? We have already done a lot of research about how to talk to the American

people about health care and what people are worried about. You know people are worried about affordability and quality. If we learn how to tap into this anxiety without scaring people, we have a chance to do something way overdue, which is to build a health care system that can reach everyone, that can be based on quality and quality improvement, that can be more affordable, that can deal with the waste in the system, and that can emphasize prevention and public health.

We can build a system that is actually patient-centered. Today, we have a provider-centered system which operates to support health care professionals and hospitals and pharmaceutical companies. As far as patients are concerned, they might as well be broken into pieces—one for pharmaceuticals, and others for this or that specialist. Often, there is not one person that knows a patient's whole situation. The system does not work well to integrate care or personalize it to individual patients. It is not a patient-centered system if it is about individual doctors with no incentives to address the patient as a whole.

Achieving a patient-centered system will entail changing how health care is paid for and having modern information technology available to everyone involved. We have the technology to do this. What is not there is the political will and the money to make it happen Even though change will be costly, doing nothing is a very expensive option. We will spend a lot more for health care if we <u>don't</u> reform the system.

The bottom line is that the urgency is there. The anxiety is there. The opportunity and tools are there. All that is missing is a catalyst or spark to bring it together. We almost had it in the early 1990's when here was a similar confluence of opportunity.

For whatever reasons, it didn't pan out in the 1990's, but we did learn something and I think that this time the stakes are so high, we simply cannot afford to fail. We can't afford to settle for the status quo because health care will become unaffordable and the quality problems will go unaddressed.

I have been saying the *opportunity* is here. In fact, the *obligation* is here—for all of us, for AARP. The next few years will be exciting. They are going to require all of us to be engaged, to put our best thoughts together. Elected officials don't know everything; they need help from us. I think it's going to be a time when we have the potential to remake American medicine in a profound way. The first revolution a hundred years ago turned medicine into a science for the first time. Now, we have a chance for a second health care revolution that can make medicine not only about the best attainable quality but also about the most personal and holistic care we know how to deliver. This is something really worth dedicating our energy and our lives.

That's where I'm going to be. That's where Ben was. I am very honored to be with you tonight because I know that's where you are, too. Thank you very much for this honor.

CONSUMER INFORMATION

Regulatory Boards Becoming More User-Friendly

Editorial Note: CAC regularly recommends that licensing boards pay attention to their user-friendliness. That is, how well do they inform the public of their existence and mission? How well to they communicate information about their disciplinary activity? How helpful are they to complainants? And so on. This story suggests that at least some states and boards appreciate the importance of these considerations. CANews is disappointed that most of the progress we have seen involves boards of medicine which are already way ahead of other professions in making information available online. Other professions need to catch up!

The **Oregon** Board of Medical Examiners (BME) devoted space in its fall 2006 **BME Report** to boast that its Website improved from number 20 (in 2005) to 11th best in 2006, according to the ranking by Public Citizen's Health Research Group. Launched in 1998, the BME Website has steadily improved, according to board executive, Kathleen Haley. During the past year, the board added malpractice information, complete texts of disciplinary orders, and online license-application status reports to its Website. Current and back issues of the board's newsletter are also accessible online, as is the current edition of *Regulations Rights and Responsibilities*, the BME's physician's handbook.

According to Ms. Haley, "This ranking represents the culmination of several years of diligent planning and hard work to make major changes in how the Board informs the people of Oregon regarding their health care providers. And, it is an ongoing process – we are constantly striving for the next level of quality in public information and public protection."

Editorial Note: CAC was pleased to be asked by the Oregon Board of Medical Examiners to critique its Web site two years ago, and many of our suggestions were incorporated into the board's redesigned site.

Urged on by a Sept 17 editorial in the ***Duluth News Tribune***, the **Minnesota** Board of Medical Practice met a self-imposed deadline of September 22, 2006 to revamp its Website. The new Website discloses original documents related to disciplinary cases and keeps them online permanently. Previously, the Website disclosed whether a physician had been disciplined, but gave few details about the cause of action or the penalty.

Virginia's Governor Timothy Kaine announced on November 13, 2007 the activation of a toll-free phone line (211-VIRGINIA) which patients can use to locate a health care professional. The phone line provides free information about Virginia's 34,000 doctors and 250,000 other health care providers, including the status of the provider's license, actions taken by the licensing board, office hours, location, languages spoken, hospital affiliation and more.

News from **North Carolina** is mixed. The state's medical board promised an improved Website a year ago but not long before it was to be activated (January, 2007), some board members argued for even more changes. A committee comprised of board

members, doctors and a trial lawyer have made recommendations to the board, some of which may require new legislation. An alternative under consideration is relying on voluntary self-reporting for some information. That approach was taken in **Florida** where it has met with criticism.

Medical Specialty Board Unveils Redesigned Website

The American Board of Medical Specialties (ABMS) has made its Website more user-friendly. According to a Dec. 4, 2006 press release:

> The American Board of Medical Specialties (ABMS), in an effort to better educate the public, professional credentialers, physicians and its Member Boards about specialty medicine and board certification, has launched its completely redesigned Web site at www.abms.org.
>
> The ABMS Web site, attracting over a million visitor sessions annually, has been updated with a new visual identity and a new navigation map which includes a "who we help" area that has specific information for consumers, professional organizations, physicians and the 24 ABMS Member Boards. Visitors can still go to the site to check whether or not their physician is certified by an ABMS Member Board. They can also learn more about the significance of board certification, the process doctors undergo to become board certified and a new method of continuous professional development, called Maintenance of Certification, a program of continual learning and improvement.
>
> "The strategy for the new Web site is to provide information about specialty medicine and board certification in ways that are meaningful to our multiple audiences," explains Stephen H. Miller, MD, MPH, and President of ABMS. "Since ABMS Member Boards certify more than 85% of practicing physicians in the United States, it was important that our visitors have a reliable and trusted place where their questions about specialty medicine and board certification can be answered."
>
> Among the site's many new features are:
>
> - links for healthcare consumers to various online educational resources including an interactive diagram about physician specialties;
> - descriptions of ABMS' tools and services that provide quality primary source information for professional credentialing organizations;

- explanations of the latest standard setting initiatives that ABMS is involved with to improve the quality of care; and
- a password protected area for the Member Boards so they can access shared resources.

"The primary goal of this redesign is to achieve broad recognition of the identity, purpose and value of board certification and ABMS as it relates to quality practice by certified specialists. In addition, we want to make the user's experience at our Web site convenient by providing an invaluable service to our visitors," said Lori Boukas, ABMS Director of Marketing and Communications. "It has enormous impact in setting the stage for our strategic communications by encouraging more professional collaborations and raising awareness about our products and services."

IN MEMORIUM

CAC Mourns Richard Morrison, Colleague and Public Member

We are sad to report that our colleague, Richard Morrison, died on March 8, 2007, from complications related to cancer therapy. We will miss Dick's intelligence and wit and his ardent support of CAC's mission and agenda. Dick was a member of CAC's first Board of Directors, and after leaving that position has worked with us on several projects, most recently promoting the implementation of continuing competence requirements as a condition of health professional re-licensure. He was an instrumental part of a current initiative by AARP Virginia to pursue continuing competence legislation in that state.

Dick not only talked the talk; he walked the walk as a diligent and effective public member in a number of settings, including the Board of Certification for Emergency Nursing and the Virginia Health Quality Center (Virginia's Medicare Quality Improvement Organization). He served on the Board of Directors of the Council on Licensure, Enforcement and Regulation (CLEAR), where he worked closely with CAC Chairman Emeritus, Ben Shimberg.

Dick was active in Virginia state government, including serving for ten years as the Executive Director of the Board of Health Professions where he was responsible for all aspects of research and policy related to that state's regulation of the health professions. He was appointed to numerous state and national advisory commissions and had academic and research appointments at a half-dozen Virginia colleges and universities.

Dick attended the University of Chicago, the College of William and Mary, and Virginia Commonwealth University, where he earned his Ph.D. in sociology.

DISCIPLINE

State Court Requires Stricter Burden of Proof in Licensure Cases

Editorial Note: The following item is excerpted from Dale Atkinson's* Counsel's Column*, entitled, "Burden of Proof Proves Burdensome," which appeared in the February, 2007 issue of the Association of Social Work Boards'* Association News. *Atkinson is a partner in the law firm Atkinson & Atkinson and counsel to ASWB. The Washington State Supreme Court decision he writes about* (Ongom v. State of Washington, 3d 1029 [WA 2006]) *has tremendous implications for licensure boards in all the professions.

As has been discussed on numerous occasions in previous newsletter articles, at ASWB assemblies, and extensively at the ASWB New Board Member Training, boards of social work must be aware of and abide by the appropriate burden of proof when taking actions against individuals at the administrative level.

To review, differing adversarial actions require differing burdens of proof (i.e., criminal matters require proof beyond a reasonable doubt and civil matters require a preponderance of the evidence). In an administrative matter against an individual under the practice act, boards of social work (or the corresponding department) must adhere to the burden of proof necessary to sustain an adverse action. The burden in administrative matters is usually the preponderance of evidence or clear and convincing evidence and can be found in the practice act or administrative procedures act…. As readers know, licensees possess a property interest in their license. Accordingly, an adversarial administrative action must satisfy "due process" requirements as part of the administrative prosecution against a license.

Many jurisdictions require a preponderance of evidence standard in order to take adverse action against a license. Recently, the preponderance standard was subjected to a constitutional analysis as it is related to the due process rights to which licensees are entitled.

(A nursing assistant registered – the equivalent of licensed for this case – in Washington State) was accused of abuse of a patient in the nursing home in which she was employed. Based on a complaint filed with the Washington Department of Health, allegations of unprofessional conduct were initiated….

The registrant, for whom English was a second language, represented herself in the administrative matter. Testimony from three witnesses and numerous documents and affidavits were made a part of the record. As acknowledged by all parties involved, the evidence was in serious conflict.

The hearing officer concluded, and so stated in his recommended order, that the state had not proven its case by clear and convincing evidence. However, Washington rules require a preponderance standard and the hearing officer concluded that the preponderance standard had been met. Washington also states that the presiding officer shall not declare any statute or rule invalid.

Based on the preponderance of the evidence standard, the hearing officer suspended the registration (or license) of the registrant for a period of 24 months…. The ruling was appealed to the superior court, which affirmed the use of the preponderance standard. The appellate court also affirmed the lower court and the matter was appealed to the Washington Supreme Court (which) phrased the issue as whether proof by a preponderance of the evidence in a professional disciplinary proceeding satisfies due process.

The court analyzed a previous decision (*Nguyen v. Department of Health)....* In *Nguyen*, the Washington Supreme Court held that a professional disciplinary proceeding subjects a doctor to grave concerns which include the "potential loss of patients, diminished reputation and professional dishonor." It also recognized the doctor's liberty interest in the license and the right to protect a professional reputation. The court held that a clear and convincing standard must be met in an administrative proceeding against a licensed physician….

In rejecting (the lower court's) analyses, the Supreme Court held that the interest of the state to protect the public welfare was just as significant in dealing with physicians as nursing assistants. It also held that a license creates a property interest, that the due process protections afforded individuals apply to all such professional licenses, and that differing burdens cannot be justified based upon the type of license at stake. Accordingly, the Supreme Court rejected the findings of the appellate court and held that the due process protections under the United States Constitution require all administrative proceedings to use a clear and convincing standard in adversarial proceedings against a licensee….

This opinion is of enormous significance to regulatory boards. While only applicable in Washington State, the analyses stimulate legal debate over the due process rights afforded licensees in administrative actions. The burden of proof necessary to sustain action against individuals accused of violating the practice act impacts all phases of an administrative investigation, prosecution, and adjudication. A clear and convincing standard applied to all administrative adjudications could change the landscape upon which such prosecutions are based. Stay tuned.

Study Reveals Factors Associated with Disciplinary Severity

Research published in the March, 2006 issue of the ***Journal of the American Osteopathic Association*** found that the factors most often associated with license revocation by medical boards are medical specialty, number of years in practice, and a history of multiple disciplinary actions. To reach this conclusion, Roberto Cardelli, DO, MPH and John Licciaradone, DO, MBA, both of the University of North Texas, studied disciplinary actions taken by the Texas Medical Board (TMB) between January 1, 1989 and December 31, 1998.

Noting from previous studies of licensing board behavior that the relationship between type of violation and the severity of discipline is unclear, the researchers chose to analyze factors associated with high-severity disciplinary action while controlling for type of violation.

For the sample studied, the TMB was more likely to revoke the licenses of physicians who had 2 or more previous disciplinary actions on record. Physicians who had been in practice longer were more likely to have their licenses revoked. Anesthesiologists, general practitioners and psychiatrists were more susceptible than other specialties to licensure revocation.

Editorial Note: Another study published in the Summer 2006 issue of* Health Matrix *magazine followed 2,247 physicians disciplined between 1990 and 1999.

Conducted by Peter Lurie of Public Citizen's Health Research Group, this study found that physicians who committed violent crimes tended to receive the most severe sanction, including license revocation. Only 6.4% of physicians who committed crimes such as rape, sexual assault, indecency with a child or public indecency received minor sanctions, such as fines, reprimands, or mandatory education. Slightly more than 1/3 of physicians who committed prescription violations or substance abuse violations received minor sanctions and 67.2% of those who committed Medicare, Medicaid or other insurance fraud received minor sanctions.

Chiropractor Sues Patient for Libel

A Massachusetts Appeals Court ruled in October, 2006 that Dr. Albert Kalter, a chiropractor, may sue a patient for libel. The patient accused Kalter of "inappropriate touching" during an office visit in 2004 and brought her complaint to the Blue Cross network, the Braintree police department and the Board of Registration of Chiropractors. According to a report in ***The Patriot Ledger***, board records include allegations of disrespect and exploitation of his position of trust by introducing sexual content into the doctor-patient relationship. When the patient exhibited modesty, Kalter allegedly ridiculed her and openly speculated that she might be frigid. The board has yet to reach a decision in the matter. At the time of writing, the board's Website indicates that Kalter has been sent a license renewal application.

Kalter sued the patient in 2004 for libel, for interfering with his business relationships and inflicting emotional distress. The patient moved for dismissal on the grounds that she was protected by a state law that prohibits suits against citizens who complain to the government. **The Appeals Court**

ruled the patient is not protected because she complained to an insurance company, not a government agency. (Emphasis added.) A dissenting opinion argued that the complaint letter to Blue Cross should qualify because it was filed under a state mandated grievance process for insurers.

Editorial Note: Among other things, this story underscores the importance of making the public aware that complaints about professional misconduct should be made to the appropriate licensing board, wherever else they may also be filed.

Nursing Error Provokes Regulatory Furor

The state of Wisconsin brought a criminal felony charge against a nurse who mistakenly administered an epidural anesthetic intravenously, causing the death of a teenaged girl. The patient was supposed to have received an intravenous dose of penicillin for a strep infection. The Justice Department's Medical Fraud Control Unit investigation found that the nurse, Julie Thao, did not follow physician's orders, didn't scan the bar code on the epidural bag which would have told her it was the wrong medication, ignored a warning label on the bag, and disregarded the hospital's rules to confirm right patient, right route, right dose, right time, right medication.

Spokespersons for the Wisconsin Nurses Association, the Wisconsin Medical Society, and the hospital objected to the felony charge, arguing that to prosecute nurses for mistakes is unfair and could discourage people from entering nursing practice, thereby decreasing access to health care in underserved areas. Prosecution, the nurses association contends, could undermine the trend toward more transparency about medical errors.

Subsequently, according to ***Nursingmatters***, published by Capital Newspapers, the Wisconsin Board of Nursing suspended Julie Thao's license for nine months after which the license will be restricted for two years during which she may not work more than 12 hours in a 24 hours period or more than 60 hours a week. Thao had worked from 8 a.m. to midnight on the day before the error. She then slept at the hospital and started work again at 7 a.m.

The Board of Nursing also stipulated that Thao:

- Provide a copy of the board's decision to supervisory personnel at all settings where she provides health card.
- Arrange for written reports from supervisors assessing her work performance to be provided to the Department of Regulation and Licensing.
- Complete a board-approved educational program within one year that addresses the roles of individuals and systems in preventing medication and health care errors.
- Make three presentations to groups of nurses or nursing students on the topic of the roles of individuals and systems in preventing medication and health care errors.

In a plea agreement, Thao pled no contest to two misdemeanors — dispensing of a drug by someone other than a pharmacist or

practitioner and possession of a drug by a person to whom it had not been prescribed. In exchange, the felony charges (negligence of a patient causing great bodily harm) were amended.

Explaining the relatively mild penalty, Larry Martin, spokesman for the Department of Regulation and Licensing, said, "The Board of Nursing has to weigh three things: protection of the public, rehabilitation of the licensee and deterrence. It is not in our purview to punish."

Medical Board Gives Confidentiality in Return for Negotiated Settlements

Twice in the past year, the Iowa Board of Medical Examiners has negotiated settlements with physicians in which the board agreed to keep the charges against the physicians confidential. In one case, a retired physician surrendered his license in return for confidentiality.

In the other case, the board kept charges against a physician confidential in return for an agreement that he have a female chaperone present when he treats female patients. The board is under a court order not to disclose charges against licensees until cases have reached a final resolution. The board has appealed that decision to the state supreme court.

Editorial Note: CAC News & Views supports transparency and is on record congratulating the Iowa board for appealing the lower court ruling that keeps charges confidential until the completion of a case. We consider it especially egregious that patients not be informed of allegations that result in a chaperone requirement. Who else but patients are going to monitor a chaperone requirement?

QUALITY OF CARE

Some Financial Quality Incentives Called into Question

A survey of physicians by researchers at the University of Chicago found that three-quarters of respondents believe that pay-for-performance incentives would be a constructive thing, if the quality measures were accurate. However, most physicians do not believe either insurers or the federal government will "try hard to make such measures accurate." A majority of respondents to the survey also disapproved of public reporting of physician-specific and group practice-specific outcomes measures.

According to the lead researcher, Dr. Lawrence Cassalino, doctors fear that inaccurate quality measures could lead to unintended consequences, such as doctors refusing to treat very sick patients, or concentrating on the variables that are measured while neglecting other areas of quality care.

The medical community is also dubious about incentive programs offered by some insurers because they tend to reward physicians and group practices that spend less money rather than rewarding quality care. The AMA sued a BlueShield plan in 2006 alleging libel and deceptive business practices for offering that kind of incentive plan.

An Issue Brief published by the Center for Studying Health System Change confirms that there are many more productivity-based

than quality-based incentive programs in existence. Written by James Reschovsky and Jack Hadley, "Physician Financial Incentives: Use of Quality Incentives Inches Up, but Productivity Still Dominates," (Issue Brief No. 108, January 2007). Based on studies of 2004-2005 data, these researchers found the 52 percent of surveyed physicians had productivity-based incentive plans, and nearly three-quarters of these physicians considered the incentives a very important factor in their compensation. In contrast, 44 percent of physicians subject to quality-based incentives viewed them as very important to their compensation, or 9 percent of all physicians.

Health Care Facilities Need to Do More to Detect Serial Killers

A report published in the December, 2006 ***Journal of Forensic Sciences*** says at least 90 health care practitioners in 20 countries have been prosecuted for serial murders of patients since 1970. The majority of murders occurred in hospitals and nursing homes. The study's authors, Beatrice Yorker, a nurse and an attorney and Dean of the College of Health and Human Services at California State University-Los Angeles, and Kenneth Kizer, MD, MPH, say that many of these murders could be prevented by good risk management practices. They hope the research will influence the hiring practices of health care organizations and improve crime-scene management practices, including post-mortem identification of medications.

Kizer told ***USA Today*** that dangerous practitioners are able to move from hospital to hospital because many hospitals do not pass on adverse information because they want to avoid lawsuits by disgruntled former employees alleging their reputations and careers have been harmed. After nurse Charles Cullen was convicted of multiple murders in hospitals in New Jersey and Pennsylvania, those states enacted laws shielding hospitals from lawsuits if they provide truthful references for former employees, no matter how damaging. The study's authors believe there should be a federal shield law applying to all U.S. hospitals.

Editorial Note: This study reinforces arguments that hospitals are advised to comply with mandatory reporting laws and thereby keep licensing boards in the loop. Boards can help hospitals and other health care organizations track suspicious patterns and identify dangerous practitioners before they do more harm.

WORKFORCE

More Nurses are Associated with Better Care

The Agency for Healthcare Research and Quality (AHRQ) reports that a study prepared by AHRQ's Minnesota Evidence-based Practice Center in Minneapolis found:

Increased numbers of registered nurses in hospitals are associated with decreased patient deaths, shorter hospital stays, and fewer occurrences of complications such as pneumonia. However, a clear cause-and-effect link between staffing level and these reductions can not be established because most published studies do not adequately evaluate the effect of quality improvement strategies and other factors that could have contributed to the improved patient

outcomes. Most studies found that a lower patient-to-nurse ratio was associated with better patient outcomes, with the greatest improvement seen in surgical patients and patients in intensive care units. Ratios of 2.5 surgical patients per nurse and 3.5 intensive care unit patients per nurse were associated with the largest decrease in poor outcomes. Each additional nurse decreased the risk of death by 9 percent for intensive care patients and 16 percent for surgical patients. In all nursing care units, each additional patient assigned to a nurse was associated with an increased risk of 7 percent for pneumonia, 53 percent for respiratory failure, 45 percent for accidental extubation, and 17 percent for complications. However, direct comparisons and the optimal nurse staffing level could not be determined because the studies used different methods to measure staffing (e.g., patient-to-nurse ratios versus the time nurses spent in direct patient care). There was insufficient evidence to determine the extent to which staffing policies (including shift length and the use of full-time, part-time or temporary staff) affect patient outcomes. There was strong evidence that health care-related deaths were lower when more of the nurses providing care had a Bachelor of Science in Nursing degree, but the effect of nursing skill mix and care provided by licensed practical nurses and licensed vocational nurses could not be determined based on the available studies

Editorial Note*: *The National Nurses Organizing Committee, a union and professional association of registered nurses formed by the California Nurses Association to organize registered nurses and to advocate for improved patient care and progressive public health policy, is promoting the adoption of nursing ratios in many states. In Texas, a Hospital Patient Protection Act was introduced in February 2007 to reduce the number of patients assigned to each nurse in that state.

Research reported in the December 11, 2006 Archives of Internal Medicine found that more registered nurses, not-for-profit hospitals, more advanced technology, and hospitals with federal or military designation all contribute to better quality care. Bruce Landon, MD, MBA, associate professor at Harvard Medical School compared hospital care for three common conditions, congestive heart failure, heart attack, and pneumonia.

Graduates of Accredited Programs for Paramedics More Likely to Pass Certification Exams

Research published in the April/June2006 issue of ***Prehospital Emergency Care*** examined the relationship between education program accreditation and pass / fail rates on the National Registry Paramedic Certification Examination. Based on the records of 12,773 students who took the test in 2002, those who attended accredited programs were more likely to pass the test. The researchers advise that more research is needed to determine what features of accredited programs account for the superior exam performance of graduates.

ACCESS TO CARE

Doctors Polled on Their Right Not to Disclose Treatment Options

Eight percent of more than 1,000 physicians surveyed by University of Chicago bioethicist, Farr A. Curlin, said they believe they have the right not to tell patients about treatment options that they, the doctors, object to on moral or religious grounds. The survey results were published in the February 8, 2007 issue of the ***New England Journal of Medicine.***

Respondents were asked their views of three controversial interventions: sedating dying patients (17 percent objected), prescribing birth control to teenagers without parental consent (42 percent objected), and performing abortions after failed contraception (52% objected). Still 86 percent of respondents said they feel a responsibility to inform patients of all options; eight percent feel no such responsibility, and six percent are undecided. Sixty-three percent believe the ethical course is to tell patients of their objections; 18 percent feel no obligation to refer patients to another doctor who will provide treatment of the patient's choice; 11 percent are undecided.

More than a dozen states have considered legislation that would either 1) require health care workers to provide treatments that are legal or 2) protect healthcare workers who have moral or religious objections to doing so.

Editorial Note: At CAC's 2006 Annual Meeting a few public members reported that their boards have been lobbied by interest groups that advocate on politically charged issues, such as reproductive choice. In response to one such comment, Basil Merenda, Commissioner of the Pennsylvania Department of State, Bureau of Professional and Occupational Affairs, advised that boards are responsible for protecting the health and safety of all consumers, for maintaining the integrity of the regulated professions, and for doing justice. Advocacy groups, he suggested, should pursue their causes through the political process if they want to change the law.

PAIN MANAGEMENT AND END OF LIFE CARE

DEA Modifies Controversial Rule

On September 6, 2006, the Drug Enforcement Administration (DEA) backtracked on a controversial rule that limited multi-month prescriptions of pain medication and antagonized members of the medical community. The DEA proposed to permit doctors to write three 30-day prescriptions at a time.

Praising the DEA for taking "an important step to improve the regulatory environment for pain care in this country," a coalition organized by the American Pain Foundation commented on the proposed rule. Among other comments, the coalition (of which CAC was a member) proposed that "'90-day supply' be changed to, 'An individual practitioner may issue multiple prescriptions at the same time, and each must bear the date that they were issued and signed, and the date on which they can be dispensed'."

Pain Doctor's Conviction Overturned

A federal appeals court three-judge panel overturned the conviction of Dr. William Hurwitz who faced 25 years in prison for a conviction of drug trafficking and fraud. The appeals court found that the lower court judge's instruction deprived the jury of the opportunity to consider Hurwitz 's defense, which was that he was practicing medicine in good faith, even while prescribing large doses of pain medication to his patients, some of whom were addicts.

Nursing Home Patients Experience Poorly Controlled Pain

The Agency for Healthcare Research and Quality (AHRQ) reported in December, 2006 that:

> An assessment using the Pain Medication Appropriateness Scale (PMAS) indicates that only one-third of nursing home residents have an excellent match between their reported pain severity and the medical prescribed to control their pain, which means that two-thirds of residents have suboptimal pain management. The PMAS lists the appropriate medication for the type of pain; appropriate dose interval (depending on whether the pain is persistent, predictably recurrent, or breakthrough pain); and appropriate titration of medication to severity of pain. The scale also lists the degree of pain relief from medication, appropriate prevention of constipation from opioids, and appropriate exclusion of drugs considered high-risk for the geriatric population. The scale is designed as a screening tool to assess overall pain management strategies in a nursing home or group of homes, and is not meant to be used to evaluate individual care plans.
>
> In this study… researchers used the PMAS to assess pain medication prescribing during a study of a multifaceted intervention to improve pain management in six rural and six urban nursing homes in one State. The mean total was 64 percent of optimal, an indication of generally poor management of pain in nursing homes. Fewer than half of residents with predictably recurrent pain were prescribed scheduled pain medication. Also 23 percent of residents received at last one high-risk medication.
>
> PMAS scores were better for residents not in pain (68 vs. 60 percent) and in homes where the nurses' knowledge of pain assessment and management improved or stayed the same during the intervention (69 vs. 61 percent). Appropriate prescribing for mild episodic pain and constipation prevention for as-needed opioids was excellent (84 and 79 percent compliance, respectively). However, prescribing was adequate for only 40 percent of the residents who had neuropathic pain.

More details are in "Assessing the appropriateness of pain medication prescribing practices in nursing homes," by Evelyn Hutt, M.D., Ginette A. Pepper, R.N., Ph.D., F.A.A., Crol Vojir, Ph.D., and others, in the February 2006 ***Journal of the American Geriatric Society***, 54,pp. 231-239.

SPOTLIGHT

Kudos to North Carolina Board of Nursing's PreP Program

CAC News & Views is pleased to shine this quarter's Spotlight on the **North Carolina Board of Nursing's Practitioner Remediation and Enhancement Project (PreP 4 Patient Safety).** One of the original nursing boards to participate in CAC's PreP 4 Patient Safety initiative, the North Carolina Board of Nursing has converted from pilot status to a permanent state-wide program. Statistics and participant surveys from the years 2005 and 2006 clearly indicate that the PreP 4 Patient Safety program is fulfilling its objectives: to identify and remediate sub-standard practitioners before patient harm has occurred and to foster cooperative working relationships between hospitals and licensing boards:

PreP Statistics

	2005	2006
Referred	53	53
Accepted	46	47

* Reasons ineligible: Facility provided appropriate remediation, licensees declined offer to participate, and mental health issues

How Reported	2005	2006
Direct Referral to PREP	18	27
Request by licensee	1	1
Complaint	34	25

Licensure	2005	2006
RN	67%	72%
LPN	33%	28%

Agency Type	2005	2006
Hospital	22	25
Long Term Care	21	15
Other (home care, office practice, public health)	3	7

Issues	2005	2006
Patient Rights (confidentiality)	0	2
Patient Care (abandonment, medication errors, failure to maintain minimum standards	12	17
Documentation (errors/omissions)	5	8
Scope of Practice (exceeding scope, delegation, supervision)	25	19
Other	4	1

Licensee Survey results:

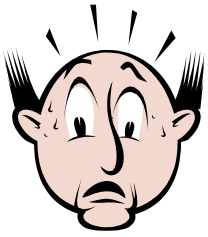
- 2006 PREP participants were surveyed regarding their experience in the program. 49% returned their surveys. (6 LPNs and 17 RNs representing 10 hospitals, 10 long term care facilities, 1 home care and 2 that were no longer employed)
- The average length of time of licensure was 11 years with the range being less than 1 year to 42 years)
- 78% perceived the process was very fair and 22% rating it fair
- 95% perceived the staff involved with PREP were courteous
- 100% perceived the program was reasonable in length for their needs
- 78% rated the quality of the program was excellent with 17% rating it as good
- 100% perceived the program was an effective way to resolve concerns with their practice
- 96% identified that their practice was enhanced by participation in PREP.

Employer Survey results:

- 9 Director/Managers responded to the survey. This represented 5 hospitals, 2 long term care facilities, and 2 office practices.
- 100% perceived the staff were courteous
- 78% identified the effectiveness of PREP as excellent 78% of the time and 22% rated it as fair.
- 67% noted improved practice of the licensee following PREP participation and 31% indicated either uncertain or no improvement.
- Overall quality of the program was rated as excellent 78% of the time, good 11% and fair 11 %.

Editorial Note: CANews is especially pleased to see an increase in direct referrals of PreP cases from hospitals (18 in 2005 and 27 in 2006). It is also noteworthy that RNs are being referred in greater proportions by both hospitals and long term care facilities. It is gratifying that both licensee (96%) and employer (67%) participants in the program believe that the nurses' practice was enhanced as a result of participation in PreP. More information on PreP 4 Patient Safety is available at www.4patientsafety.net.

Horror Case of the Quarter



Optometry Board Avoids Misstep

The Oklahoma Board of Examiners in Optometry saved itself from major embarrassment when it retracted a proposed rule change that would have prohibited optometrists from providing care in nursing homes more than 60 miles from the optometrist's main office. It appears that an article and follow-up editorial in the ***Tulsa World*** about the proposed action had something to do with the board's decision to cancel a scheduled public hearing and withdraw the proposed rule change for at least this year.

According to the ***Tulsa World***, there are only three optometrists who travel the state to provide services to long term care facility residents, one of whom was featured in the newspaper coverage. He travels two days a week and sees bed-bound patients who would otherwise have to be transported by ambulance to an optometrist's office.

The licensing board's rationale, the board chairman told the ***Tulsa World,*** arose from a concern that visiting optometrists would not give proper follow-up care, even though the board has not received any complaints about deficient follow-up care.

The ***Tulsa World's*** editorial (January 17, 2007) began with this observation:

> Most people would assume that a healthcare governing board would want to ensure timely and regular access to that care. But a proposal being considered by the state optometry board, some say, would actually make eye care unavailable to many vulnerable Oklahomans. Why in the world would the optometry board want to do that?

Explaining the cancellation of the public hearing, the board executive director blamed the weather, but he did attribute the board's decision not to reschedule the hearing to public opposition to the rule.

Notice: Our new website makes it easy for you to provide us with updated information about your board. Simply go to http://www.cacenter.org and select "Update My Contact Information".

To join our free mailing list, go to http://www.cacenter.org and provide us with your email address.

For links to over 25 websites of interest to readers of this newsletter, go to http://www.cacenter.org and select "Resources".

LETTERS

Dear CAC News & Views:

I was just leafing through your latest “News and Views” and thought about sharing an initiative that the New Jersey Board of Chiropractic Examiners has launched.

We have traditionally offered a “Jurisprudence” examination to our new licensees. The board had expressed an interest in requiring its licensees to participate in a New Licensee Orientation Program, but we thought that having new licensees physically present themselves would present an undue burden. We have solved the problem by engaging the services of a company to marry the New Licensee Orientation with the Jurisprudence Examination in an online offering.

The vendor filmed my board members and me giving a section-by-section presentation of the board’s laws and regulations, along with some narrative providing real life examples of infractions and some of the ethical underpinnings of the regulations (such as sexual misconduct). The program is offered as a “Web Streaming” format accompanied by Power Point slides that are in sync with the video. Candidates are given a password and access the program through our Website. After each section of the program, candidates close the presentation and are asked a series of 2-3 multiple choice or true/false questions that pull from an item pool. The questions are not only drawn from the presentation, but also come from the regulations themselves. Once they have completed the questions, they can check their answers, and then proceed to the next presentation. There are eight separate presentations including, an Introduction to the Board and its Enabling Statute, Patient Records, Scope of Practice Diagnostic Testing, Fraud and Abuse, Advertising, Sexual Misconduct, and Administrative Responsibilities (renewing your license, filing notice of change of address, etc.) At the end, the candidates review all answers and the program electronically grades the exam and prints out a pass-or-fail notice. If they fail, they cannot repeat the program for 72 hours. There is a fee of $50.00 for the program, which is paid to the vendor….

Sincerely,

Kevin Earle, MPH, Executive Director
NJ Board of Chiropractic Examiners
NJ Board of Dentistry
NJ Board of Acupuncture Examiners
NJ Midwife Liaison Committee