News & Views

Citizen Advocacy Center

Third Quarter, 2007 A Health Care Public Policy Forum Volume 19 Number 3

Announcements

CAC News & Views is now available for download in PDF format. When viewed onscreen, the Table of Contents includes links to all of the articles.

SAVE THE DATES: *Our 2008 meeting will be held on Monday, Tuesday, and Wednesday, October 27, 28, and 29, 2008, at the Renaissance Hotel in Asheville, North Carolina. It will be co-sponsored by The Health Licensing Boards of North Carolina. Please visit our website at www.cacenter.org for more information.*

SCOPE OF PRACTICE

Wyoming to Consider Licensure of Denturists

Denturist Gary Vollan sued when Wyoming's Board of Dentistry charged him with practicing dentistry without a license. The case went to the State Supreme Court, which ruled in favor of the board and against Vollan in August, 2007.

Vollan hasn't given up. He is gathering signatures on a petition to put the issue to a vote in the 2008 election. Meanwhile, state Representative Lorraine Quarberg plans to introduce legislation in the next session that would give denturists their own licensure board. An earlier bill that would have licensed denturists under the dental board failed to get out of committee. Quarberg told Joan Barron of the ***Casper Star Tribune*** (www.casperstartribune.net) capital bureau that she feels strongly that denturists provide a valuable service that deserves to be licensed separately.

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Governor Vetoes Prescriptive Authority for Psychologists

By using her veto power in July, Hawaii's Governor Linda Lingle earned the gratitude of the state's psychiatrists, the AMA, and others who opposed granting psychologists authority to prescribe psychotropic medications. In her veto message to the legislatures, Lingle wrote:

> ….The stated purpose of this bill "is to authorize appropriately trained and supervised licensed medical psychologists practicing in federally qualified health centers to prescribe psychotropic medications for the treatment of mental illness." The bill is objectionable because its actual effect goes beyond its stated purpose by allowing psychologists who obtain the second of the two tiers of prescriptive authority established by the bill – a prescription certificate – to practice outside of federally qualified health centers (FQHCs) and to prescribe medications to individuals who are not patients of FQHCs. Furthermore, this bill does not require medical supervision of psychologists holding a prescription certificate.
>
> This bill is also objectionable because psychologists do not have the training necessary to prescribe drugs and this bill does not require sufficient didactic and clinical training for prescriptive authority. Modeled after the Department of Defense's Psychopharmacology Demonstration Project (PDP), this bill differs significantly from the PDP. With respect to the didactic training differences, the bill lacks classroom training in two core areas, cell biology and clinical pharmacology, that is required by the PDP. Regarding the clinical training differences, the PDP specified the number of hours required

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and how many months must be inpatient and outpatient experience, whereas this bill fails to do so. The PDP, furthermore, required close supervision by a psychiatrist with advanced training in psychopharmacology while this bill only requires supervision two hours a week by a physician or psychiatrist….In addition, this bill gives psychologists with prescriptive authority a scope of practice broader than that afforded the PDP psychologists. PDP psychologists were limited to prescribing psychotropic medications to patients between the ages of 18 and 65 with mental conditions but without medical complications as evaluated by the supervising psychiatrist. This bill allows psychologists to prescribe psychotropic medications to patients of all ages, including children, elderly, and those with medical illnesses in addition to mental conditions. Psychologists with limited didactic and clinical training are not prepared to handle the side effects of psychotropic medications on patients with medical complications.

Interestingly, both the Board of Medical Examiners and the Board of Psychology asked the Governor not to sign the legislation. Reportedly, the Board of Psychology did not want to take on the responsibility for medical oversight mandated in the bill.

California Experiments with Registered Dental Hygienists in Alternative Practice (RDHAP)

The Center for the Health Professions at the University of California, San Francisco is working on a study entitled, "Registered Dental Hygienists in Alternative Practice (RDHAP): Current and Future Contributions to Increasing Access to Dental Care." Visit www.futurehealth.ucsf.edu for information about the study and preliminary data presented in PowerPoint format.

The Web site explains the reason for the study:

> Lack of access to dental care is a persistent problem for vulnerable populations in California resulting in extensive untreated dental disease, particularly in children. To address this, the State has invested in multiple programs and policies aimed at improving access to dental treatment. A complementary strategy is to promote disease prevention by increasing the availability of preventive services in a variety of non-dental office settings. The development of the Registered Dental Hygienist in Alternative Practice (RDHAP) is one such endeavor. California is a unique testing ground for this new model of dental hygiene practice. It is critical that policy makers understand this new effort and provide support for new strategies to meet the oral health needs of our growing and diverse population.

The study seeks to examine the impact that RDHAPs currently have on

expanding access to care for vulnerable populations and to examine the policies and/or administrative issues that may be preventing them from effectively delivering prevention services in areas of need…. A final report is expected in November, 2007.

BOARD AUDITS

Washington State Audit Critiques Regulatory Boards

Last year, the ***Seattle Times*** wrote a series of articles critical of the state's regulation of health professionals, focusing in especially on instances of sexual misconduct. Governor Christine Gregoire promptly ordered an audit of the Department of Health and its Health Professionals Quality Assurance Office. The auditors reported their findings in August, 2007. Governor Gregoire wrote the following letter about the audit to the regulatory boards via Cabell Tennis, Chair, Medical Quality Assurance Board:

> Dear Mr. Cabell:
>
> As you are aware, the State Auditor's Office issued its performance audit of Health Professions Quality Assurance on August 21. I have read the audit and the Department responses. I strongly support the use of performance audits as an important tool to improve state government and it is clear that the Department took this performance audit seriously.
>
> Like you, my top priority is patient safety. Both the Department and you have specific roles in licensing the right people, taking timely and consistent action when patients are being harmed, and making sure that health care providers are being properly supervised when their ability to practice is restricted. All patient safety activities must be handled in a consistent, timely and effective manner. As you know, in May 2006, I asked Secretary Mary Selecky to adopt rules regarding sexual misconduct and uniform guidelines for sanctions for all professions.
>
> Thank you for adopting rules regarding sexual misconduct. The audit report strongly recommends that all boards and commissions adopt Secretary Selecky's sanction guidelines. Most boards and commissions have already done so. For those who have not, I ask you to adopt the Secretary's sanction guidelines immediately. That way, we can ensure that unprofessional conduct is treated seriously and consistently.
>
> The audit report recommends use of a common set of threshold guidelines to identify those cases to investigate. I expect the Department to share its threshold criteria and checklist with you and ask all boards and commissions to adopt these criteria.
>
> The report finds that the court cases have slowed the decision to investigate cases in recent years. Investigations will move faster if boards and commissions delegate the decision to investigate to

Department staff through rulemaking. I encourage you to do so.

The audit confirms my belief that it is vital to have uniform, consistent, standardized approaches to credentialing and disciplinary activities. You will continue to see the Department move in this direction as the reorganization of the Health Systems Quality Assurance Division moves forward. I have asked the Secretary to address three specific areas identified in the performance audit that have significant impact on patient safety. I am directing the department to proceed with these immediately:

- Develop specific criteria to assess complaints for imminent danger. There should be no question that the state will intervene when patients are in danger of imminent harm.
- Adopt mandatory reporting rules by March 2008. The Department can only take action to protect patients when it knows there is a risk of harm. Mandatory reporting is one of the best ways to find out that patients are at risk since practitioners and facilities are in the best position to identify inappropriate practices.
- Move quickly to organize credentialing and compliance practices to assure that these activities are handled in a timely, consistent and effective manner across all health care professions.

I urge you to support Secretary Selecky's effort as she responds to my direction. Thank you in advance for your continued commitment to protecting patient safety.

For more about the Governor's reaction to the audit, visit: www.governor.wa.gov.

Editorial Note: We are looking forward to an informative session on the audit and the Department's response at CAC's Annual Meeting in Seattle, October 29-31, 2007.

Audit Blasts Oregon State Board of Nursing

A review team appointed by the Department of Administrative Services issued a highly critical assessment of the Oregon State Board of Nursing on August 27, 2007, causing the resignation of board executive, Joan Bouchard, and the appointment of an interim executive director. Governor Ted Kulongoski ordered an audit of the board after a series of critical articles appeared in the ***Portland Tribune*** in 2006. The articles alleged that the board was concealing from law enforcement officials information about nurses suspected of committing crimes and allowing nurses in the impaired professionals program to continue to work while under treatment. (***See elsewhere in this issue that the Medical Board of California has disbanded its impaired professionals program***.)

The auditors confirmed the problems uncovered in the newspaper stories. Among their findings:

- The board has struggled with balancing supervision of the practice of nursing with protecting the public health, safety and welfare.
- The board's deliberations appear to lack "an acute sense of urgency to protect the public" as months or years pass before action is taken against a licensee.
- Potential criminal behavior is not always quickly reported to law enforcement.
- Problems in important areas, such as the nurse monitoring program, are addressed only in response to outside pressure rather than internal initiative.
- The criminal background check process is inadequate.
- Expenditures for such things as furniture and refreshments are excessive and inappropriate.

The auditors made numerous recommendations related to licensure, investigations, operations, the nurse monitoring program, and personnel and financial management. These include:

- Improved criminal background checks;
- Immediate reporting of alleged criminal acts to law enforcement;
- Legislative changes to allow for automatic suspension or revocation for conviction of specified crimes;
- Legislative changes to the nurse monitoring program to limit participation to self-referrals and to mandate suspension of a nurses license to practice while in the monitoring program;
- Empowering staff to make proposed determinations for certain types of disciplinary findings, under appropriate guidelines and supervision;
- Consider adopting disciplinary guidelines;
- Develop consistent policies and procedures for investigators;
- Hire temporary staff to reduce case backlogs;
- Provide additional training for staff and investigators;
- Record all board proceedings, including executive sessions;
- Require the board to meet at least monthly;
- Take several steps to improve monitoring of participants in the nurse monitoring program and hold participants accountable for conforming to the terms of their treatment;
- Consider moving the monitoring program from the control of the board of nursing;
- Reorganize the staff and reduce the number of staff reporting directly to the executive director.

A deputy staff member was fired shortly after the audit report was issued, and additional changes at the board have been predicted.

Audit Says New York Medical Board Should Be More Proactive

In September, 2007, New York State Comptroller, Thomas DiNapoli, reported on an audit of the complaints and investigations process of the Office of Professional Medical Conduct, the discipline arm of the state medical board. The audit found that:

> OPMC is thorough in its investigation of cases of potential misconduct, and generally does effectively track complaints. However, OPMC management concentrates little effort on proactively identifying cases of potential misconduct or ensuring that they have received all complaints from the various outside and internal reporting sources. In addition, OPMC needs to improve the timeliness of some of its investigations.

To correct these deficiencies, the Comptroller recommended that OPMC:

- adopt procedures for determining whether it is receiving complaints from the outside sources that are supposed to report (including Medicare and Medicaid, the bureau of hospital services, and the AG);
- identify potential cases of fraud by reviewing Medicare and Medicaid data bases;
- adopt procedures for initiating investigations involving physicians with more than three malpractice payments in five years;
- ensure that investigators have manageable caseloads (between 35 and 40 cases at any one time);
- adopt standards for the timely completion of investigations, and do a cost benefit study to determine the resources needed to meet the standards.

The complete audit report can be found at: www.osc.state.ny.us

QUALITY OF CARE

Temporary Nurses Provide Quality Care

A study published in the July/August issue of the ***Journal of Nursing Administration*** (www.jonajournal.com) concludes that the use of temporary nurses by hospitals does not lower the quality of care. The research was conducted under the leadership of Linda Aiken, a professor in the University of Pennsylvania's School of Nursing. The article's abstract explains:

> Objective: To promote evidence-based decision making regarding hospital staffing, the authors examined the characteristics of supplemental nurses, as well as the relationship of supplemental staff to nurse outcomes and adverse events.
>
> Background: The use of supplemental nurses to bolster permanent nursing staff in hospitals is widespread but controversial. Quality concerns have been raised regarding the use of supplemental staff.
>
> Methods: Data from the 2000 National Sample Survey of Registered Nurses were used to determine whether the qualifications of supplemental nurses working in hospitals differed from permanent staff nurses. Data from Pennsylvania nurse surveys were analyzed to examine whether nurse outcomes and adverse events differed in hospitals with varying proportions of nonpermanent nurses.

Results: Temporary nurses have qualifications similar to permanent staff nurses. Deficits in patient care environments in hospitals employing more temporary nurses explain the association between poorer quality and temporary nurses.

Conclusion: Negative perceptions of temporary nurses may be unfounded.

Pneumonia Risk Tied to Nurse Patient Ratio

A study published in the July 19 issue of the online publication, ***Critical Care*** (www.ccforum.com.) found that low nurse to patient ratios (averaging between .42 nurses per patient two to four days before early onset infections and .78 nurses per patient two to four days before late onset infection) resulted in a higher incidence of pneumonia in ICU patients on respirators. According to the study's authors, ventilator-associated pneumonia can increase hospital stays by as much as 50 days and results in much higher costs.

Lead author, Dr. Stephane Hugonnet, attributed higher infection rates to several factors. These include, too heavy a work load, failure on the part of nurses to comply with basic hygiene rules, job satisfaction, and burnout.

New York Regulates Surgery in Doctors' Offices

Editorial Note: The number of ambulatory surgery centers (ASCs) has increased dramatically in number in recent years – by 25% between 2001 and 2006, according to the Joint Commission. Medicare recognizes more than 4,600 ASCs. Many of these centers are unregulated and some observers are concerned about the quality of care in ASCs that have neither the appropriate staff nor the equipment to provide adequate postoperative and emergency care. The same or greater concerns apply to surgery performed in doctors' offices. The following item is excerpted from an article by CAC Board Member, Arthur Levin, which appeared in the August, 2007 **HEALTHFACTS,** ***a newsletter from the Center for Medical Consumers (www.medicalconsumers.org). He writes about regulations enacted earlier this year in New York State to regulate surgery performed in doctors' offices. CAC recommends that public members of boards that license the practitioners who work in ambulatory surgery centers and doctors' offices urge their boards to work with facility regulators in their states to enact and enforce regulations at least as strong as those in New York.***

The public may be surprised to learn that the circumstances under which doctors can perform surgery and provide anesthesia in their private offices is generally unregulated, allowing serious harm to go unreported. All that will soon change in New York State, which recently passed one of the nation's toughest laws regulating surgery performed in private doctors' offices.

I served as the consumer member of the state task force that proposed this new law. It requires all offices where surgery involving more than minimal anesthesia (e.g. local, topical anesthesia) is performed to be accredited by one of several national organizations selected

by the commissioner of health. Such organizations develop and oversee safety standards and practices for office-based surgery. Among other things, these standards require an office to have appropriately trained personnel and the equipment to deal with emergencies.

Another important change brought by New York State's new law is the requirement that surgeons report all serious adverse events related to surgery done in their office to the state health department. A growing number of other states, including Florida, California and New Jersey, have a similar requirement.

Mandating that doctors report serious patient harm is long overdue, because there is almost no data on the comparative safety of the ten million (and growing) office-based surgeries estimated to occur each year. Some years back, a rash of disastrous office-based liposuctions was front page news in Florida and led to that state's requirement of reporting of patient harm.

A 2003 analysis of these reports found the risk of patient harm was ten times greater for the same surgery done in private doctor offices, compared to outcomes in regulated surgery centers.

From a patient's perspective, having surgery performed in a doctor's office may appear to offer advantages. A private office may provide more attractive surroundings, greater convenience and for procedures not covered by insurance, less expensive. Furthermore, given what we know about medical errors and deadly infections running rampant in hospitals, avoiding inpatient stay may sound like a good thing.

Those advantages pale, however, if patients cannot be assured that their surgeon's office meets the same safety standards required of licensed hospitals and surgery centers. In the absence of such standards, for example, there may not be resuscitation equipment or trained personnel to deal with an emergency….

Questions Raised About Insurers' Doctor Ratings

In August, 2007, Attorney General Andrew M. Cuomo attracted national attention when he warned Aetna and CIGNA Healthcare that their physician ranking programs, as currently designed, are likely to confuse or even deceive consumers. The preceding month, he asked UnitedHealthcare to cancel its plans to introduce physician ratings.

In letters to Aetna and CIGNA, Attorney General Cuomo expressed concern about the design of the programs and requested a full justification for them. "Transparency and accurate information are essential when consumers make healthcare decisions," wrote Attorney General Cuomo. "We will ensure that insurance companies are not obscuring important facts at the consumers' expense."

Cuomo cited "the problematic design" of the physician ranking programs: "the rankings are based on claims data, which is, according to the AG, well-known to carry several significant risks of error when used to rank individual physicians; the insurers do not disclose the accuracy rate of their rankings; and insurers have a profit motive to recommend doctors who cost less, not necessarily those who are most qualified."

The letters explain that inaccurate physician ranking programs may cause financial harm to consumers because some employers steer employees to the doctors preferred by the insurer by lowering co-payments or deductibles. Consequently, employees who choose not go to the preferred doctors could pay more.

Copies of the letters sent by Attorney General Cuomo are available at www.oag.state.ny.us.

A similar CIGNA initiative in Connecticut prompted a lawsuit by individual physicians and the medical society alleging libel, unfair trade practices, and breach of contract when CIGNA identified "elite" physicians. The medical society in Washington State sued Blue Cross when it ranked physicians based on efficiency and quality and eliminated 500 physicians from its network. This suit was settled and the insurer agreed to work with the medical society on any future ranking project and to provide the terminated physicians with an external review process. Over the objections of the state medical society, Texas Blue Cross has introduced a members-only, Web-based comparison of physicians based on affordability and conformance with evidence-based practice guidelines.

Editorial Note: Meanwhile Commonwealth Fund President Karen Davis and Stuart Guterman recommended in the September 2007* Milbank Quarterly *modifications in the Medicare payment system that would combine fee-for-service payments with payments based on episodes of care. They argue that such a system would create incentives for providers to deliver both high-quality and efficient care. Under the current system of fixed rates for services, providers are rewarded for being efficient, but they are also rewarded for providing more services, as opposed to appropriate or coordinated services. Paying for care by episode of treatment or over a set period of time would reward care coordination and chronic care management, according to Davis and Guterman.

For more on this, visit www.commonwealthfund.org.

A Web site, www.RateMDs.com allows consumers to rate their doctors in four areas: punctuality, helpfulness, knowledge, and overall quality, and to enter personal comments, favorable or unfavorable. As of this writing, 356,002 ratings had been posted about 115,256 practitioners, including physicians (by specialty), dentists, midwives, psychologists, and acupuncturists. In CAC's view, the usefulness of the site is limited by the fact that raters are self-selected and all ratings are anonymous.

WORKFORCE

Faculty Shortage Said to Threaten Healthcare Workforce

The Association of Academic Health Centers (AAHC) contends that faculty shortages are threatening U.S. health professions educational infrastructure. A survey of CEOs of academic health centers found that 94 percent believe that faculty shortages are a problem in at least one health professions school and 69 percent believe faculty shortages are a problem for the entire institution.

Although the shortages affect most institutions and almost all professions, shortages of nursing faculty are considered the most troublesome. Eighty-one percent of CEOs say they are a problem and 45 percent say they are "very much a problem." In other professions, 77 percent of CEOs say faculty shortages are a problem in allied health, 71 percent in pharmacy, 70 percent in medicine, 67 percent in dentistry, and 55 percent in schools of public health.

Academic health centers are employing several strategies to respond: limiting student enrollment, cutting programs, and merging programs. CEOs say that neither state nor federal government officials appear to appreciate the seriousness of the problem.

The complete report is available at www.aahcdc.org.

ROLE OF THE PUBLIC MEMBER

Hospital Advisory Councils Tap Expertise of Patients and Families

The Institute for Family-Centered Care headquartered in Bethesda, Maryland is working with hospitals in the US and Europe to create patient advisory councils to contribute to decision-making on a variety of levels from evaluating equipment, designing new space, constructing clinical trials, reviewing medication safety procedures, training medical residents, and responding to consumer complaints.

The Institute has developed guidelines for the advisory councils and offers a variety of helpful resources for hospitals and advisory council members on its Web site, www.familycenteredcare.org. On the topic of "Essential Allies," the Web site reads:

> Throughout the country, families and professionals are working together in new ways. They are collaborating to develop care services for individual children and their families, and increasingly, they are forming collegial partnerships at the program and policy level. A consensus is growing that these collaborative approaches humanize the service delivery system, improve outcomes for children, and result in greater satisfaction both for providers and families. Families are realizing that they can impact and influence policies and programs. Providers are recognizing that consumer involvement is integral to designing a service system that is

both responsive and cost effective….

Experts in the field of family-centered care have observed that "(t)he presence of parents' or consumers' voices in policy-making conference rooms is not a natural phenomenon. When it does exist, it reflects a deliberate attempt to expand the set of traditional decision-makers to include the users of services." (Epstein, Taylor, & Wells, 1990, New England SERVE)….

When you visit the Institute's Web site, be sure to follow the link to Laura Landro's August 8 article in ***The Wall Street Journal***, entitled "Hospitals Boost Patients' Power." The article describes the many ways patient advisory panels are influencing hospital policies and operations across the country.

Editorial Note: Patient Advisory Councils are analogous in many ways to public membership on regulatory boards and other health professional oversight bodies. They share a goal: involving patients and consumers in making decisions that affect their care.

The pre-conference Public Member Training session at CAC's upcoming Annual Meeting will include a session about "Two-way Communication with the Public." At the session, consumer and community groups will identify health care issues of concern to their members. The public members in attendance will then discuss how their boards might help resolve some of these issues and how public members can help boards maintain communication with such community groups. We are pleased that a Seattle-based representative of the Institute for Family-Centered Care will be a presenter at this session because Patient Advisory Councils are among the consumer and community organizations that public members and their boards should approach to take a reading of the issues affecting health care consumers.

Public Member Reports to Board on CAC Annual Meeting

Cathie Maxaner, Public Member of the Pennsylvania Board of Psychology wrote a lengthy report to her board about CAC's 2006 Annual Meeting in Williamsburg, Virginia. In addition, her yearly newsletter article was based on ideas she took home from CAC's meeting. She wrote, in part:

Accountability Through Transparency was the theme of the 2006 Citizen Advocacy Center (CAC) Annual Meeting. As an advocate for the public at large on the Board of Psychology, it is appropriate to share some perspectives gleaned from my participation….

The Board of Psychology has a duty to protect the public through licensure, enforcement, and information. Since regulatory boards exist primarily for public protection, *Accountability Through Transparency* emphasizing more user friendly health care boards was an appropriate point of departure. Various "Accountability Through Transparency" scenarios were discussed.

Outreach to the public both outside and at board meetings was stressed. Some ideas for transparency included timely and convenient opportunities for public comment on policy and rule making proposals. In this regard, one jurisdiction offers Website public comment through Regulatory Town Meetings. The same jurisdiction also utilizes a Board of Health Professions as a sounding board for regulatory study requests from board, director, legislator, governor, public, board members, staff and consultants.

Another idea was board member and staff presentations to consumer and community groups. In addition, readily available suggested information included brochures, phone book board listing, licensing and consumer notice postings in offices, printed and voice media news releases and Website comprehensive information.

Also discussed was transparency in disciplinary action information available to the public at large…. Another example providing more transparency to the process was one state's Sanctioning Reference Study… to assure consistency, neutrality and sanction appropriateness….

Significantly, the 21st Century public at large demands greater citizen empowerment and greater accountability in health care…. (T)he communication explosion is a challenge due to the plethora of available information (reliable and unreliable), the ease of obtaining information and the rapidity of its transmittal.

Ironically, the information paradox raises additional issues for regulatory boards (in) balancing the public desire for empowerment and accountability with fairness to licensees. The public needs to have good people practicing the profession in an accountable way, upholding appropriate standards. Clearly, public protection is primary.

And as a corollary, more *Accountability Through Transparency* will result in greater citizen confidence in the profession.

Editorial Note: CAC is always gratified to receive evidence such as this that public members have taken ideas from our annual meeting and other forums back to their boards. Even better than her report about the meeting, Cathie Maxaner went home from the Williamsburg meeting and recommended that her board consider forming a Consumer Education Outreach committee with a goal of "furthering communication and knowledge about the mission of the Board of Psychology."

CONTINUING COMPETENCE

NOCA Considers Developing Standard for Assessment-Based Certificate Programs

Editorial Note: The National Organization for Competency Assurance (NOCA) is considering developing a standard for assessment-based certificate programs of the type health care practitioners may attend to meet continuing education requirements. CAC encourages NOCA to undertake this endeavor in the belief that standards for CE courses could make them far more credible components of a comprehensive program for ensuring the current competence of health care practitioners as a condition of relicensure. The following information is taken from the NOCA Web site, www.noca.org.

NOCA is holding a public meeting to discuss the potential development of a National Standard defining the minimum quality requirements for assessment-based certificate programs. The scope of the project is intended to cover certificate programs which are relatively short, non-degree granting programs that provide instruction and training to aid participants in acquiring knowledge / skills / competencies and designate that participants have passed an end-of-program assessment derived from the learning / course objectives.

A NOCA Task Force has completed the development of a defining features document that provides an outline of minimum requirements for a quality assessment-based certificate program. This document will be used as a platform for further discussion and debate leading to a voluntary consensus standard.

If sufficient support is obtained to proceed, NOCA will facilitate the development of the standard in a manner to be consistent with Public Law 104-103 and Office of Management and Budget (OMB) Circular A-119 which establishes policies on Federal use and development of voluntary consensus standards. Also, in anticipation of this standard being submitted for consideration as an American National Standard the development process will be consistent with the Essential Requirements of the American National Standards Institute (ANSI). It is intended that the standard will be written in a manner to be suitable for use by third-party accreditation bodies since there is an anticipated need for this type of service.

To ensure as much opportunity as possible for interested parties to participate in the open meeting NOCA will be holding the meeting at its headquarters in Washington D.C. as well as providing access to the discussions through a webcast.

IN-DEPTH

Editorial Note: During the Attorney Roundtable at the Federation of State Medical Board's meeting in May, 2007 there was much discussion about a perceived need for licensing boards to find alternative approaches to disciplining physicians for minor infractions lest the board's disciplinary action result in automatic cancellation of the physician's certification by an American Board of Member Specialties (ABMS) member board. Recalling that some years ago, licensing board officials alleged incorrectly

that managed care plans automatically de-list physicians who have been disciplined by medical boards, CAC wrote to ABMS to determine the organization's actual policy in regard to physicians who have been disciplined by a licensing board. This quarter's In-Depth feature consists of the correspondence between CAC and ABMS which establishes that it is neither ABMS policy, nor the practice at ABMS member boards, to automatically rescind the certification of physicians disciplined by licensing authorities for minor infractions.

Stephen H. Miller, MD MPH
President and CEO
American Board of Medical Specialties

Dear Dr. Miller:

Per our recent phone conversation, I will greatly appreciate your advising me about the policies of ABMS member boards relating to the eligibility of certificate holders (diplomates) of ABMS member boards when a diplomate has been disciplined by a state medical licensing board.

Let me describe the issue that has arisen. A significant number of individuals who serve on the boards of state medical licensing boards, and senior staff of these boards, have stated in private conversations that there is a growing hesitancy to take a reportable disciplinary action against a licensed physician for "minor" infractions of their state's practice act because, in their words, "that will lead to AUTOMATIC (my emphasis) revocation of their ABMS member board credential" or will "make them ineligible for recertification when it is time for renewal of that credential." This allegation is often made by persons who come from states where even "letters of concern" are public and reportable.

A number of years ago this same concern was expressed to me regarding AUTOMATIC "de-listing" by HMOs and other managed care organizations when the HMO learned that a physician had been subject to ANY disciplinary action by a state medical licensing board, regardless of the seriousness of the offense. This "let's go easy" attitude was disturbing to us at the Citizen Advocacy Center, as you might imagine. I made inquiries at that time as to the correctness of this assumption, and was told in no uncertain terms that the assumption was NOT TRUE. I learned that virtually all managed care organizations would inquire into the circumstances that led to the disciplinary action, and would only "de-list" a physician if the disciplinary action was based on a serious violation of the practice act leading to the disciplinary action.

I suspect the same is true for ABMS member boards. That is to say, when a member board learns of a disciplinary action by a state medical board, there is NOT an AUTOMATIC revocation of the physicians board certification, nor is it AUTOMATIC that the physician would be ineligible to renew his/her certification. Rather, what I suspect is that each member board would look behind the board's disciplinary action, and make a case-by-case determination whether the physician's board certification should be revoked, or whether that physician would be eligible for recertification (assuming of course the individual met all other requirements). In other words, an ABMS member board might, on a case by case basis, allow a physician to maintain his/her board certification if the underlying reasons for the disciplinary action were judged to be "minor", not serious.

That is what I suspect. But what will be enormously helpful to all of us at CAC will

be to have YOU explain ABMS member board policies with regard to MINOR infractions that led to licensing board discipline, rather than have me speculate on your member boards' policies. (Of course we would expect that in cases where licensing board discipline was for a serious infraction, then the offending physician's board certification would indeed be rescinded and/or that physician would be ineligible for recertification.)

Thank you in advance for your advice and counsel on this matter.

David A. Swankin, Esq.
President and CEO
Citizen Advocacy Center

ABMS General Counsel, William McVisk responded in the following email:

----Original Message-----

From: William McVisk

Subject: ABMS Member Board Policies Re Response to Licensure Actions

Dear Mr. Swankin - Steve Miller asked me to respond to this, as General Counsel for the ABMS. As you know, each ABMS Member Board has its own standards and procedures for dealing with diplomates who have licensing problems. However, ABMS policy specifies that each board should require all diplomates to maintain a full and unrestricted license in all states in which the physician practices or has a license. There is no requirement that a Member Board suspend or revoke the certificate of a diplomate as the result of minor disciplinary measures. The only requirement ABMS has for its Member Boards is that they require all diplomates to maintain current and unrestricted licenses. Thus, if a state imposes a sanction that is does not restrict, suspend or revoke the license (such as a letter of reprimand), a Member Board would not be obligated to take any action with respect to the diplomate's certificate.

Also, we are not aware of any Member Boards that automatically suspend or revoke any diplomate's certificate without notifying the diplomate in advance and affording the diplomate the opportunity to respond.

We hope that this addresses your question. Please feel free to contact me if you need additional information.

William McVisk
ABMS General Counsel

Subsequently, ABMS submitted a proposed policy statement on "Minimum Standards for Full and Unrestricted License" to its board of directors for approval in September, 2007. This proposed policy statement said the following about exceptions to its general policy that in order to be certified, physicians must have a full and unrestricted license:

> ***Exceptions to policy. ABMS Member Boards may allow a physician to be certified, recertified or maintain certification even though the physician's license has been voluntarily surrendered or has lapsed in one or more jurisdictions provided that the physician was not practicing in the jurisdiction at the time the license was surrendered or allowed to lapse and the license was not surrendered or allow to lapse to avoid sanctions by the jurisdiction's licensing authority. ABMS Member Boards may also allow a physician to be certified, recertified or maintain certification even though the physician's license to practice medicine***

has been restricted, suspended or revoked in one or more states provided that the physician establishes all of the following:

a. The physician has full, unrestricted license to practice medicine in all states in which the physician currently practices medicine;

b. The medical licensing authorities in the states in which the diplomate is currently practicing have been fully apprised of any restrictions or adverse actions concerning the diplomate's medical license in all other states in which the diplomate's license is restricted, suspended or revoked and the reasons therefore and have concluded, after learning of the restrictions or other adverse action, that the physician's license should not be restricted, suspended or revoked; and

c. Additional circumstances exist which, in the judgment of the Board, justify allowing the physician to be certified, recertified or maintain his or her board certification despite the fact that the physician does not have an unrestricted license to practice medicine in all states in which the physician has held a license to practice medicine.

LICENSURE

CAC Opposes CMS Proposal to Change PT Examinations

Editorial Note: CAC sent the following letter to the Centers for Medicare and Medicaid Services in September, 2007 to register our opposition to a proposal that would shift responsibility for testing physical therapists from the licensing authority to the professional society. The proposal was contained in "CMS-1385-P - Therapy Standards and Requirements."

Gentlemen:

The Citizen Advocacy Center (CAC) submits this comment on the above-referenced proposed rules published in the Federal register on July 12, 2007. Under the proposed rules, the definition of "physical therapist" in Section 484, Title 42 of the CFR would be changed. Under the proposed rules, physical therapists would, among other things, be required to pass a national examination approved by the American Physical Therapy Association (APTA), a private professional association.

CAC is a not-for-profit 501-C-3 organization serving the public interest by enhancing the effectiveness and accountability of health professional oversight bodies. We offer training, research and networking opportunities for public members and the health care regulatory, credentialing, and governing boards on which they serve.

CAC opposes the proposed rule change, and urges CMS not to make this rule final. There is absolutely no justification to support this rule. We say this as an organization that strongly supports national uniformity in testing of all types of health professionals. For the physical therapy profession, national uniformity in testing is already the case. In order to be licensed in any of the 50 states, a physical therapist must take and pass the National Physical Therapy Examination (NPTE) developed and administered by the Federation of State Boards of Physical Therapy (FSBPT). Not only is there in place a national test, there is a single national passing score.

Unlike APTA, the FSBPT is not a private professional association whose mission is to promote the interests of the physical therapy profession. Rather, FSBPT is an organization composed of the state physical therapy licensing boards. These boards, created by their state legislatures, have a different mission than APTA. The boards are statutorily mandated to protect and promote the public health and safety, and are mandated to ensure that only qualified individuals who pass the NPTE and who meet all other statutory and regulatory requirements are licensed to practice. One need only look at the medical profession to understand the difference between relying on the licensing board community to develop qualifications tests, and relying on private professional associations whose mission, as stated above, is different. A few years ago, in medicine, the American Medical Association (AMA) opposed the creation of an additional exam (USMLE III) by the Federation of State Medical Boards (FSMB) and their partner, the National Board of Medical Examiners (NBME). The USMLE III requires medical students demonstrate satisfactory communications skills before they are allowed to enter a residency, making passing the test a condition of licensing in the several states. Had the AMA been in charge of test development, there would be no such requirement.

For CMS to consider handing over to a private professional association (in this case APTA) the power to decide what will and will not be included in a qualifications exam runs the risk that the exam will not be as rigorous as it should be, and runs the risk of compromising public health and safety. It is an unnecessary risk for CMS to take in the case of physical therapists, because, as stated above, there already exists a national exam subscribed to by all state physical therapy licensing boards.

CMS currently relies exclusively on state licensing in defining "doctors of medicine" and "registered nurses." It should do the same for physical therapists.

Sincerely,

David A. Swankin, Esq.
President and CEO, CAC

IMPAIRED PRACTITIONERS

California Board Ends Diversion Program

The California Medical Board voted unanimously on July 26, 2007 to terminate its diversion program for chemically dependent physicians. The program will be phased out by June, 2008.

The program has been criticized repeatedly during its nearly 30 years of existence. In 2004, Julianne D'Angelo Fellmeth included a harsh critique of the diversion program in her report as the medical board's Enforcement Monitor (See *CAC News & Views*, Volume 17 Number 2, Second Quarter, 2005). More recently, in June 2007, the California State Auditor found many problems with the program. Most damaging, the program is charged with permitting physicians to continue to practice while receiving treatment and, at the same time, not adequately monitoring the physicians in the diversion program. The June audit report noted other problems, including:

- The diversion program does not adequately ensure that it receives

required monitoring reports from its participants' treatment providers and work-site monitors.

- The diversion program has reduced the amount of time it takes to bring new participants into the program and begin drug testing, but the timeliness of testing falls short of its goal.
- The diversion program has not always required a physician to immediately stop practicing medicine after testing positive for alcohol or a nonprescribed or prohibited drug, thus putting the public's safety at risk.
- Twenty-six percent of drug tests in June and October 2006 were not performed as randomly scheduled.
- The diversion program's current process for reconciling its scheduled drug tests with the actual drug tests performed needs to be improved.
- The diversion program has not been formally evaluating its collectors, group facilitators, and diversion evaluation committee members to determine how well they are meeting program standards.
- The medical board has not provided consistently effective oversight of the diversion program.

For more on the audit, visit: http://bsa.ca.gov/reports/highlights.php?id=536.

Editorial Note: As far as we know, California has been unusually diligent in monitoring and auditing the medical board's diversion program. The many audit reports and the medical board's response should be a bellwether for impaired practitioner programs in other professions and other states. CAC News & Views urges public members to ask their boards to evaluate their diversion programs, or, better yet, to request an outside evaluation by a state agency. To support their case, public members can cite the California audits and an audit of the Oregon Board of Nursing referenced elsewhere in this issue which found similar problems with its diversion program.

PAIN MANAGEMENT AND END-OF-LIFE CARE

National Pain Care Legislation Pending

The National Pain Care Policy Act of 2007 was introduced in the House of Representatives on July 11, 2007 by Representative Lois Capps (D-CA) and Representative Mike Rogers (R-MI). The legislation would create an inter-institute Pain Consortium at the National Institutes of Health. It would also authorize the Institute of Medicine to convene a conference on pain care.

The legislation would create a grant program to improve the ability of health care professionals to diagnose and treat pain. It would also authorize the Department of Health and Human Services to create a public awareness campaign about pain management. Particular attention would be paid to appropriate pain care for underserved populations.

The legislation is supported by the American Cancer Society and the American Pain Foundation, among others.

Congress Delays Tamper-Resistant Rx Pad Rule

Senators Sherrod Brown and George Voinovich announced the passage of

legislation to delay the implementation of a tamper-resistant prescription pad rule which they say could leave Medicaid participants without essential prescription drugs. According to a press release issued by the Senators:

> U.S. Senators Sherrod Brown (D-OH) and George Voinovich (R-OH) announced Senate passage late September 25, 2007 of legislation introduced last week that would provide more time for Medicaid recipients and pharmacists to comply with a new rule effective October 1. A bill earlier this year included a provision requiring all Medicaid prescriptions to be written on tamper proof paper to avoid fraud. Currently, most physicians do not use these pads and supplies are not readily available, especially in rural areas. The Brown-Voinovich Bill would delay implementation of the rule for six-months.
>
> "The purpose of the tamper proof requirement is to combat fraud, not create chaos for patients and pharmacies" said Senator Brown, a member of the Health, Education, Labor, and Pensions (HELP) Committee. "I'm pleased this bipartisan bill passed the Senate. We'll keep working until it's signed into law."
>
> "We must do everything we can to eliminate fraud and abuse in the Medicaid program and protect patient safety," Senator Voinovich said. "Yet, as important as these priorities are, they cannot come at the expense of law abiding citizens who rely on Medicaid to obtain the prescription that keep them alive. This amendment is a common sense solution that will ensure Medicaid beneficiaries maintain access to the medicine they need to manage conditions such as diabetes and heart disease, while phasing-in a system to make the Medicaid prescription drug benefit work harder and smarter."
>
> In 2006, doctors wrote approximately 330 million prescriptions for Medicaid beneficiaries – 11 percent of the nearly 3.1 billion total prescriptions written each year. The new requirement, if implemented before doctors are prepared to comply with it, will be especially hard on small, family-owned pharmacies. The deadline leaves little time for federal and state Medicaid officials to educate doctors and pharmacists about the requirement.

New York State Passes Palliative Care Law

The Palliative Care Education and Training Act was passed in New York State in April, 2007. Initiated by the New York chapter of Compassion & Choices, the legislation is the first of its kind in the U.S. According to Compassion & Choices, the legislation will accomplish to following:

- Establish undergraduate and graduate palliative care education and training programs to expand the capacity of medical students, residents and the institutions that train them to provide high quality palliative care.
- Allow the Department of Health to designate Centers for Palliative Care Excellence, thereby encouraging hospitals to develop the kinds of quality staffing and services that would benefit patients across the state.
- Allow the Department of Health to authorize Palliative Care Practitioner Resource Centers to enable practitioners to access the latest palliative information over the phone or online. This would be a private

service offered by any institution or organization that can qualify, and would be paid for by practitioners through subscriber fees.
- Create the New York State Palliative Care Education and Training Council, comprised of leaders in the fields of palliative care and pain management, to provide the state with the expertise it needs to guide state policy.
- $4.6 million a year is authorized, primarily for the training programs.
- This historic legislation will establish New York as a leader in pain management and palliative care by expanding the capacity of practitioners, medical schools, hospitals, hospices and other community-based providers to provide cutting-edge pain management and palliative care services across the state.

For more information, visit www.compassionandchoicesofny.org.

Alzheimer's Association Issues Dementia Care Recommendations

Recognizing that more than fifty percent of residents in assisted living and nursing homes have some form of dementia or cognitive impairment, the Alzheimer's Association joined with leaders in dementia care to develop evidence-based *Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes.* The recommendations come in three phases. Phase 1 focuses on good dementia care, including food and fluid consumption, pain management, and social engagement. Phase 2 concentrates on wandering, falls, and physical restraints. Phase 3 addresses end-of-life care.

The care goals of the recommendations are:

- To use person-centered, culturally sensitive approach to providing care that meets a resident's changing needs and respects his or her preferences regarding end-of-life care.

- To minimize the resident's physical, emotional and spiritual distress, while maximizing comfort and well-being in a manner consistent with an individual's preferences regarding end-of-life care.
- To ensure open and ongoing communication among the resident, proxy decision maker, family and care team so that all parties have a clear and common understanding of what constitutes optimal end-of-life care for the individual resident.
- To provide support to families, other residents and staff, when an individual is dying and after death has occurred to help them achieve meaningful closure.
- Care plans need to be flexible enough to adapt to daily changes in a resident's needs and wishes.

For the complete recommendations, visit www.alz.org/documents/DCPRphase3_.pdf

CONSUMER INFORMATION

Washington State Reviews Exemptions to Open-Records Laws

At the request of Attorney General, Rob McKenna, Washington State has begun a review of the more than 360 exemptions to the state's open-records laws. In keeping with McKenna's support for transparency in

government, the task force's progress will be posted at www.atg.wa.gov/opengovernment/sunshine.aspx.

At its Sept 18, 2007 meeting, the task force reviewed the following proposed "Criteria for Evaluation of Exemptions:"

Primary consideration

Could the withholding or release of the information put an individual's safety at risk?

Other considerations (no ranked order)

Could the withholding or release of the information…

- put an individual's or organization's privacy at risk?
- put an individual's or an organization's financial interest at risk?
- put the safety of the general public at risk?
- promote government efficiency?
- significantly save taxpayer money?

Can the exemption be time-limited?

Can the exemption be clarified or narrowed?

Is the withholding or release of the information directed by federal law?

Does the exemption continue to be necessary given the passage of time and changes in government?

Editorial Note: CAC is a strong supporter of transparency in government. We recognize, however, that there are situations in which it is good public policy to make limited amounts of information non-public. For example, in CAC's PreP for Patient Safety program (see: www.4patientsafety.net), model memoranda of understanding between hospitals and licensing boards call for information about practitioners undergoing remediation to be non-public, but the information is shared with the licensing board.

IN THE LEGISLATURES

Law Ends Medical Society Control of Medical Board

A suit challenging the North Carolina medical society's power to choose members of the state medical board was withdrawn in August, 2007 when the governor signed legislation reducing the medical society's influence. Responsibility for nominating people to fill vacancies on the board will now rest with an 11 member panel. Four members will represent the medical society. The remainder of the seats will be occupied by representatives of the Old North State Medical Society, the N.C. Osteopathic Medical Association, the N.C. Academy of Physician Assistants, the N.C. Council of Nurse Practitioners, and the public.

The legislation signed by Governor Easley will also require the board to make more information about physicians available on its Web site. The site already provides information about educational background and disciplinary actions by the board. Under the new law, physician profiles will indicate where they have practice privileges and whether these privileges have ever been suspended or revoked. Consumers can also learn whether physicians are board-certified and / or licensed in other states. The board has the authority to publish information

about malpractice payments and felony records.

HORROR STORY OF THE QUARTER

Pharmacy Professor Accused of Breaching National Licensure Exam

Professor Flynn Warren, Jr. is facing federal charges that he disseminated questions from the North American Pharmacist Licensure Examination (NAPLEX) and the Georgia Multistate Pharmacy Jurisprudence Examination (GA MPJE) to students in his board review course at the University of Georgia College of Pharmacy. Warren is alleged to have asked students taking the licensure exams to memorize questions and send them to him so he could repackage them and use them in his exam preparation course.

The National Association of Boards of Pharmacy (NAPB) (www.nabp.net) took swift action when it learned of the alleged breach of the exams, filing suit on August 3. On August 6, U.S. Marshals seized materials and computers from the school and from Warren's office. At an emergency meeting of its Executive Committee on August 23, NAPB decided to suspend all administrations of both exams "to ensure that the integrity of the examinations is maintained and that NABP develop and provide only valid and psychometrically sound examinations to the state boards of pharmacy." It is estimated that the loss of thousands of test items will cost NABP millions of dollars and necessitate a massive overhaul of the exam pool.

In an affidavit, NABP Executive Director, Carmen Catizone, said that his review of files obtained from Warren, "revealed at least 633 'sample' questions (that were) contained in Warren's 'review course' and/or were made available by Mr. Warren to candidates who gave him their e-mail addresses.

Editorial Note: If the allegations are proven to be true, CAC finds it appalling that a professor of pharmacy would compromise the integrity of a licensure examination, and thereby expose patients down the line to potential harm from pharmacists whose licenses have been obtained fraudulently and, perhaps, undeservedly. Not to mention that one would expect an academician would neither want to compromise the credibility of the institution where he works, nor want to see students evaluated on a non-level playing field.

DISCIPLINE

Oregonian Explores Pharmacy Board's Policy *vis-à-vis* Dispensing Errors

In a June 20, 2007 article in ***The Oregonian*** (www.oregonlive.com), Andy Dworkin explores in detail the approach taken by Oregon's and other Boards of Pharmacy toward licensee dispensing errors. His research uncovered 836 dispensing error complaints to the board between 1996 and 2006, ranging from minor errors in dosage to dispensing the wrong medication. In 2005-6, none of the pharmacists with dispensing errors was given serious penalties (probation, suspension, or revocation) by the board. Most were fined and some were required to take three hours of continuing education on avoiding dispensing errors.

National Association of Boards of Pharmacy (NABP) executive director, Carmen Catizone, confirmed that most boards of pharmacy treat dispensing errors as unintentional mistakes and choose lenient penalties if there has been no patient harm. "Some people in the professions are saying that pharmacists should never be penalized for dispensing errors." Catizone told Dworkin. "The boards of pharmacy are saying they can't take that approach, particularly when a patient has been injured."

Dworkin uses the case of Dr. David Hochhalter to illustrate the Oregon board's disciplinary philosophy. Hochhalter had repeated appearances before the board for dispensing errors between 1998 and 2001 – some potentially serious, although they were caught before the patients took the drugs. His penalties were reprimands or fines until 2001 when he was given two years' probation. Hochhalter ultimately lost his license in 2004 for a combination of violations, including failing to keep records, disobeying the terms of his probation, failing to report an arrest on his license renewal form, and overcharging insurance plans for filling prescriptions.

Editorial Note: This places boards of pharmacy squarely in the national debate about where to draw the line between 1) non-punitive approaches to errors, on the theory that this will encourage reporting and help prevent a recurrence of the same error in the future, and 2) taking disciplinary action to take a potentially dangerous practitioners out of practice, if only temporarily for remediation. It's one thing to fine a pharmacist and require continuing education after there has been a dispensing error, but after a series of dispensing errors, there is reason to worry that the next one might be the bad one that does result in patient harm.

Iowa Appeals Court Affirms Public's Right to Know

The Iowa Court of Appeals ruled May 9, 2007 that the state Board of Medicine must release certain details about allegations of misconduct against licensees. The ruling overturned a lower court decision that specifics about allegations against Dr. Eduardo Reveiz should remain confidential pending a formal hearing at which the doctor could defend himself.

The Board of Medicine appealed the lower court decision and was joined by the Iowa Freedom of Information Council which is comprised of newspapers, TV and radio stations, librarians, and organizations such as the League of Women Voters that advocate for government transparency. Had the lower court ruling been allowed to stand, it would have meant Iowa consumers would not be able to find out the specific nature of allegations against any professional licensed by the state.

The information which Reveiz wanted kept confidential alleged that he "demonstrated a pattern of professional incompetency and practice harmful or detrimental to the public in his care of several patients." This pattern included failure to diagnose appendicitis in two instances, and failure to diagnose testicular torsion, leading to the removal of one of the patient's testicles.

Virginia Medical Board Gives Staff More Authority

The Virginia Board of Medicine will give its staff more discretion to decide whether low-level cases require the attention of the board. It is hoped this will help the board reduce a

backlog of more than 2,000 complaints and meet the Governor's goal of resolving complaints within 250 days.

Previously, members of the 18-member board were involved in reviewing all complaints, with the primary responsibility falling on the chairman. Under the new system, the board's executive director will have the power to close less serious cases where the investigation does not find a violation of the statute.

Health Research Group Releases 2006 Medical Board Rankings

In June, 2007, Public Citizen's Health Research Group (HRG) released its annual ranking of medical board disciplinary action for 2004-2006. Excerpts of the report appear below:

> There were 2,916 serious disciplinary actions taken by state medical boards in 2006, down 10.4 percent from the 3,255 serious actions taken in 2005. The national average disciplinary rate was 3.18, compared to 3.62 in 2005. The three-year state disciplinary rates ranged from 1.41 serious actions per 1,000 physicians (Mississippi) to 7.30 actions per 1,000 physicians (Alaska), a 5.2-fold difference between the best and worst states.
>
> **Worst States** (those with the lowest three-year rate of serious disciplinary actions).
>
> …. (T)he bottom 10 states, those with the lowest serious disciplinary action rates for 2004-2006, were, starting with the lowest: Mississippi (1.41 actions per 1,000 physicians); South Carolina (1.45); Minnesota (1.45); South Dakota (1.52); Nevada (1.68); Wisconsin (1.78); Washington (2.06); Delaware (2.22); Maryland (2.25); and Connecticut (2.34).
>
> (F)ive of these 10 states, (Delaware, Maryland, Minnesota, South Carolina, and Wisconsin) have been among the bottom 10 states for each of the last four three-year periods.
>
> Nine states have experienced at least a 10-place drop in ranking between the 2001-3 ranking and the 2004-6 ranking: Alabama went from 13th to 26th; Georgia from 15th to 25th; Idaho from 14th to 24th; Mississippi from 20th to 51st; Nevada from 33rd to 47th; New Jersey from 24th to 40th; North Dakota from 3rd to 19th; South Dakota from 37th to 48th; and Virginia from 30th to 41st.
>
> **Best States** (those with the highest three-year rates of serious disciplinary actions).
>
> The top 10 states for 2004-6 are (in order from the top down): Alaska (7.30 serious actions per 1,000 physicians); Kentucky (7.10); Wyoming (6.37); Ohio (6.01); Oklahoma (5.54); Missouri (5.43); Iowa (5.32); Colorado (5.24); Arizona (5.12); and Nebraska (4.91).
>
> Seven of these 10 states (all but Iowa, Missouri, and Nebraska) have been in the top ten for all four of the three-year average periods in this report. Seven states have

improved by at least 10 places from the 2001-3 ranking to the 2004-6 ranking. Most notable are Nebraska and Missouri, now both among the top 10 states. Nebraska improved from 28th to 10th and Missouri from 31st to 6th. Illinois improved from 35th to 12th; North Carolina from 41st to 16th; Tennessee from 44th to 29th; Pennsylvania from 45th to 32nd; and Hawaii from 51st to 33rd.

Discussion

These data demonstrate a remarkable variability in the rates of serious disciplinary actions taken by the state boards. Only one of the nation's 15 most populous states, Ohio, is represented among those 10 states with the highest disciplinary rates. Absent any evidence that the prevalence of physicians deserving of discipline varies substantially from state to state, this variability must be considered the result of the boards' practices. Indeed, the ability of certain states to rapidly increase or decrease their rankings (even when these are calculated on the basis of three-year averages) can only be due to changes in practices at the board level; the prevalence of physicians eligible for discipline cannot change so rapidly.

Moreover, there is considerable evidence that most boards are under-disciplining physicians. For example, in a report on doctors disciplined for criminal activity that we published in the last year, 67 percent of insurance fraud convictions and 36 percent of convictions related to controlled substances were associated with only non-severe discipline by the board.

In this report, we have concentrated on the most serious disciplinary actions. Although the FSMB does report less severe actions such as reprimands, it is not appropriate to provide such actions with equal weight as license revocations, for example. A state that embarks on a strategy of switching over time from revocations or probations to fines or reprimands for similar offenses should have a rate and a ranking that reflects this decision to discipline less severely.

A relatively recent trend has been for state boards to post the particulars of disciplinary actions they have taken on the Internet. In October 2006, Public Citizen's Health Research Group published a report that ranked the states according to the quality of those postings. The report showed variability in the quality of those websites akin to that reported for disciplinary rates in this report. There was no correlation between state ranking in the website report and state ranking in this disciplinary rate report (Spearman's rho = 0.0855; p=0.55). A good website is no substitute for a poor disciplinary rate (or vice versa); states should both appropriately discipline their physicians and convey that information to the public. However, no state ranked in the top 10 in both reports.

> This report ranks the performance of medical boards by their disciplinary rates; it does not purport to assess the overall quality of medical care in a state or to assess the function of the boards in other respects. It cannot determine whether a board with, for example, a low disciplinary rate has been starved for resources by the state or whether the board itself has a tendency to mete out lower (or no) forms of discipline. From the patient's perspective, of course, this distinction is irrelevant….

The full report can be found at www.citizen.org/publications.

Britain Finds Foreign-Trained Doctors More Likely to Be Disciplined

After three National Health Service doctors were charged with attempting to set off car bombs in London and Glasgow the British General Medical Council (GMC) has launched an inquiry into the competence of foreign medical graduates. A finding that foreign graduates are more than twice as likely to face disciplinary hearings and three times as likely to be struck from the UK medical register has caused the regulator to commission seven more research studies into physician competence and the possibility of racism within the health service.

Currently, doctors from the European Union may register to treat patients in the UK without being tested for competence and without proving they can speak English. Similarly, it has been reported that hundreds of junior doctors have not been subjected to criminal background checks.

PATIENT SAFETY AND MEDICAL ERRORS

Pharmacies Act to Reduce Prescription Errors

An article by Sandra Levy in the July 9, 2007 issue of ***Drug Topics*** notes recent publicity about patient injury as a result of prescription errors at chain pharmacies (according to the Commonwealth Fund, more than one in five Americans reports that they or a family member experienced a medical or prescription drug error) and lists a number of measures pharmacies are implementing to try to reduce errors and improve patient safety. These include:

- Upgrading computer systems and workflow procedures, sometimes in consultation with pharmacists. One chain enters each prescription into a computer prior to the filling process so the exact prescription can be consulted at any time during filling. Another chain has enabled alert messages for similar-sounding medication, bar-coding matches prior to counting a medication, color-imaging for verifying the medication, required documentation of significant interactions, and onscreen imaging of the original prescription next to the entered information for easy side-by-side comparison.
- Carefully screening and training pharmacy technicians. One chain requires pharmacy techs to be at least 18 years old and to become company certified in counseling procedures and job responsibilities. Others encourage their pharmacy techs to obtain certification from the

Pharmacy Technician Certification Board.

- Requiring employees to follow quality assurance checklists, including confirming the patient's identifying information, the prescriber's name, and the medication name and strength when pulling it from the shelf. Cross-checking bar codes, color imaging, and medication monographs are other quality assurance measure used by pharmacy chains.
- Utilizing new technologies, such as robotics and biometrics.
- Promoting teamwork and sensible workflow and following the recommendations of the Institute for Safe Medication Practices and using the National Association of Chain Drug Stores' Patient Safety Virtual Toolbox.

More information may be found at www.drugtopics.com and www.nacds.org.

Medicare No Longer Pays for Treatment of Preventable Errors

The Centers for Medicare and Medicaid Services (CMS) proposed a new rule in August, 2007 saying that CMS will no longer pay hospitals for treatment of "conditions that could reasonably have been prevented," and that the hospitals may not bill beneficiaries for any charges associated with a hospital-caused complication. The conditions CMS will no longer pay for include objects left in the body during surgery, air embolisms, blood incompatibility, falls, a heart infection that can occur after surgery, urinary tract and vascular infections resulting from improper use of catheters, and pressure ulcers.

Patient safety advocates anticipate that this new rule will result in more practitioners and hospitals following practice guidelines and more testing to assess patient conditions upon admission to a hospital. Some health care providers fear that private insurers will follow CMS' lead and adopt similar policies, leaving hospitals to foot the bill. Hospital spokespersons contend that some of the conditions on the list are not entirely preventable, even when practitioners follow practice guidelines.

Editorial Note: CAC views the new CMS policy positively, believing it will provide yet another incentive for hospitals to focus on patient safety. We note with interest that a growing number of hospitals report to the quality-improvement organization, the Leapfrog Group, that they will no longer charge for the 28 serious errors called "Never Events." These events include wrong-site surgery, serious medication errors, leaving a foreign object behind after surgery, discharging a baby to the wrong mother, and falls that result in serious injury or death.