News & Views

Citizen Advocacy Center

Second Quarter, 2008 A Health Care Public Policy Forum Volume 20 Number 2

Announcements

Our 2008 annual 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 various Health Licensing Boards of North Carolina. The preliminary program and a registration form may be downloaded from our website: http://www.cacenter.org.

PowerPoint Presentations from the multi-disciplinary Continuing Competence Workshop that we held on May 12 and 13, 2008, are now available on our website at: http://www.cacenter.org/PowerPoint2008/index.html

ADMINISTRATION

Washington State to Experiment with New Administrative Structure

Legislation signed into law in Washington State in March 2008 creates a five-year pilot project under which the boards of medicine and nursing will hire their own executive directors who will then hire subordinate staff. The dental and chiropractic commissions had permissive language, but decided not to participate in the pilot at this time, so they will continue to receive administrative support from the Department of Health.

The relevant legislation language reads as follows:

> The pilot project shall include the following provisions:
>
> (a) That the secretary shall employ an executive director that is:

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(i) hired by and serves at the pleasure of the commission;

(ii) exempt from the provisions of the civil service law;

(iii) responsible for performing all administrative duties of the commission, including preparing an annual budget, and other duties as delegated to the executive director by the commission;

(b) That, prior to adopting credentialing fees, the secretary shall collaborate with the commission to determine the appropriate fees necessary to support the activities of the commission;

(c) That, prior to the secretary exercising the secretary's authority to adopt uniform rules and guidelines, or any other actions that might impact the licensing or disciplinary authority of the commission, the secretary shall first meet with the commission to determine how those rules of guidelines, or changes to the rules or guidelines, might impact the commission's ability to effectively carry out its statutory duties…

(d) That the commission shall negotiate with the secretary to develop performance-based measures. The performance expectations should focus on consistent, timely regulation of health care professionals; and

(e) That in the event there is a disagreement between the commission and the secretary that is unable to be resolved through negotiation, a representative of both parties shall agree on the designation of a third party to mediate the dispute.

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NOTICE

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Thank you!

When the pilot project reaches a conclusion in December, 2013, the secretary and the medical and nursing commissions will report to the governor comparing the efficiency and effectiveness of licensing and disciplinary functions during the pilot project and prior to the pilot. The comparison must cover timeliness, personnel resources, budgetary activity, consistency of decision making, performance levels in comparison to other disciplinary authorities, and evaluation against national research and data regarding effectiveness and patient safety.

The full text of HB 1103 can be found at: http://apps.leg.wa.gov/billinfo/summary.aspx?bill=1103&year=2007

DISCIPLINE

Medical Board Proposes to Expand Grounds for Disciplinary Action

The Massachusetts Board of Registration in Medicine has proposed a revision of its rules to reflect changes in the practice of medicine and to clarify the regulations for physicians and the public. Predominant among the proposed changes is an expanded list of grounds for disciplinary action. Additions to the present grounds include a definition of "failure to show good moral character" that applies both within and outside the actual practice of medicine.

The Board has held two public hearings on the proposal and received testimony from the Massachusetts Medical Society objecting to the expanded grounds for discipline. Interestingly, Dr. Bruce Auerbach, speaking for the medical society, claimed that the board's proposal lacked legitimacy because the board has no sitting public members and, therefore, was not properly composed to propose sweeping changes in the regulations.

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In addition, he objected in his written testimony to the proposed requirement that applicants and licensees "demonstrate good moral character as determined by the Board." He went on to explain:

> "While the MMS is strongly supportive of good moral character for our members and all licensees, we agree, as did the full board in 2006, that this term needs further specificity and should be in the context of the practice of medicine.

> Board disciplinary action should be based on concerns relevant to the practice of medicine and should place licensees on notice as to what the Commonwealth considers inappropriate enough to warrant professional discipline. Open-ended requirements which set standard as determined by the Board completely eliminate all the statutory protections which the Division of Administrative Laws Appeals affords, since the basis of the review is whether it can be shown that the licensee violated regulations, not whether the regulations themselves were rational or fair."

The complete proposed regulations can be found at: http://www.massmedboard.org/public/pdf/draft_regs_02_20_08.pdf.

Chiropractor Sues Department of Health over Business Restriction

Continuing with the subject of grounds for discipline, an Omaha chiropractor has sued the Nebraska Department of Health and Human Services charging that a business practice restriction affecting chiropractors, but not other heath care practitioners, is unjustified and unfair. The regulation in question prohibits chiropractors from telemarketing.

Attorneys for the plaintiff told the ***Lincoln Star Journal*** that "There is no rational basis for the distinct classification of chiropractic physicians as the sole medical healthcare providers who are subject to licensure discipline for violation of (the challenged law).

Public Citizen Releases Annual Ranking of Medical Boards

Public Citizen's Health Research Group released its annual ranking of medical boards in April 2008. The data shows a decrease in the number and rate of serious disciplinary actions against physicians for the third straight year to 2.92 actions per 1000 physicians. Taking into account the increase in number of physicians since then, the number and rate of serious disciplinary actions has fallen 22% since 2004.

There has been considerable shifting in the rankings with eleven states dropping at least 10 spots in the ranking between 2001 – 3 and 2005 – 7. Ten states have advanced at least ten spots in the ranking during the same period.

Public Citizen's report can be found at www.citizen.org/pressroom/release.cfm?ID-2645.

New York Medical Board Discipline Scrutinized

The Public Citizen statistics found New York State took the second most disciplinary actions in 2007 behind Illinois. However, of the 311 disciplinary actions taken against doctors in New York State in 2007, 56% were reciprocal actions – actions based on discipline taken in another jurisdiction.

Observers fear that ranking that high on the Public Citizen list could interfere with the prospects of a reform proposal advanced by Governor David Paterson. The legislation proposed by Paterson would permit the Office of Professional Medical Conduct to initiate investigations based on malpractice histories, to make public the names of

doctors charged by the board with violating the practice act, and give the board more powers to force doctors to turn over records needed for investigations.

The Department of Health says the New York board has a higher hurdle for in-state cases because it must prove two instances of wrongdoing, rather than just one in other states. The board also claims it has too few investigators to handle the complaint load of more than 7,300 (in 2005).

VOLUNTARY CERTIFICATION

ABMS to Build Public Trust in Board Certification

The American Board of Medical Specialties (ABMS) Assembly voted in May, 2008 to undertake a three-year campaign to enhance public trust in board certification. As explained on the ABMS Website (www.abms.org):

> The American Board of Medical Specialties (ABMS), the not-for-profit organization that oversees physician certification in the United States through its 24 Member Boards, announced today approval of a new initiative designed for the public to enhance physician performance assessment. Called the ABMS 2008-2011 Enhanced Public Trust Initiative, its goal is to enhance the ABMS Board Enterprise's role as a trusted private sector agent when it comes to physician accountability and to expand resource offerings for the public's need.
>
> For the past 75 years, ABMS and its Member Boards have been a leading and trusted resource for consumers and healthcare professionals seeking information on physician qualifications. Today the need for reliable information is even greater than ever as the quest to improve the quality and efficiency of medical care in the United States has become paramount.
>
> "Consumers are taking a more active role in their own healthcare decisions and are demanding greater transparency, which is a good thing," said Kevin B. Weiss, MD, ABMS president and CEO. "ABMS is in a prime position to be a leading voice for physician accountability in the quality movement, but we cannot do so without first assuring the public of our renewed commitment to ensuring quality of care. To meet consumers' expectations, ABMS and its Member Boards will work together to attain the next phase of healthcare leadership with the public's interest as our foremost concern."
>
> To launch the initiative two task forces will be established, one to examine how ABMS' governance can be more responsive to the need for public transparency in physician accountability. A second task force made up of public and medical professional members will convene to guide the design and implementation of new program initiatives that will strengthen ABMS' offerings as a trusted public agent. The task force will broadly focus on a number of proposed programs that aim to increase public trust, streamline and enhance value in ABMS Maintenance of Certification™ (MOC) and increase capacity through enhanced activities in national health policy, international program development and the expansion of research

activities and performance evaluation.

"This is an exciting time for ABMS and its Member Boards as we have the opportunity to collaborate, with public input, to achieve our shared goals," Dr. Weiss said.

The resolution was approved May 16, 2008, by the ABMS Assembly authorizing the new initiative which was originally presented on March 18, 2008, by the ABMS Board of Directors. The Assembly voted to pass the resolution by more than the two-thirds majority required.

NBCOT to Introduce Clinical Simulation Testing

The National Board for Certification in Occupational Therapy, Inc. (NBCOT) announced in its Spring/Summer 2008 ***Report on the Profession*** that beginning in 2009 its certification examination will be a hybrid test including simulation items in addition to the multiple choice items currently in use. According to NBCOT, simulation testing is a form of assessment that simulates the types of situations newly certified occupational therapy practitioners are likely to encounter in their practice. The items are designed to measure a candidate's knowledge and critical reasoning ability sequentially across the continuum of care, for example: screening; formulating treatment needs and priorities; implementing interventions; and assessing outcomes.

NBCOT explains to its readers that the move to simulation testing was driven by:

1) The mission of NBCOT to serve the public interest.

    - Results from the latest NBCOT practice analysis study indicate current job demands require certificants to have a higher level of critical reasoning abilities compared with earlier studies.
    - Assuring key stakeholders that certificants have met a minimum practice standard by differentiating between competent and incompetent practitioners.

2) Changes in OT education requirements

    - Transition to the post-baccalaureate degree
    - Revised ACOTE standards

3) Certification industry trends

    - Simulation testing is being used by other allied health and medical certification bodies who use defensible constructs to assess critical clinical competencies: i.e., physician assistants and counseling.

Simulation testing has two components:

1) A problem component, presenting the opening scene along with an array of decisions/actions that can be taken for each problem.

2) A feedback component, through which candidates can learn the results/consequences of the decisions/actions they have selected. Feedback is revealed response-by-response as the candidate makes their selections, so that a candidate only receives information on the statements and actions he/she has chosen throughout the course of the problem. From the list of decisions/actions, a candidate will score points for indicated (positive) actions and have points deducted for actions that are negative and hinder the resolution of the presented problem(s). Candidates will

neither have points awarded nor deducted for selecting a neutral response option.

Pharmacy Technician Certification Proposed in U.S. Congress

H.R. 4591 introduced in the U.S. House of Representatives in February, 2008 by U.S. Rep. Steve LaTourette would amend the Public Health Service Act to authorize grants to States to establish and implement programs for registering pharmaceutical technicians. Called "Emily's Act" after Emily Jerry who died from an overdose of salt administered by a pharmacy technician, the Act would specify that state-based pharmacy technical registration programs have certain characteristics. Under the bill, such programs would have to:

- prohibit an individual from performing the duties of a pharmaceutical technician unless the individual is registered by the State Board of Pharmacy;
- require for registration that the individual meet certain requirements related to education and training; and,
- submit an annual report to the Secretary on pharmaceutical technician errors in the state.

The bill recommends through an expression of the sense of Congress that State Boards of Pharmacy should strive to ensure (1) a ratio of two pharmaceutical technicians to each pharmacist in hospital settings; and (2) a ratio of three pharmaceutical technicians to each pharmacist in other settings, including drug stores.

CONTINUING COMPETENCE

Federation of State Medical Boards Advances Maintenance of Licensure Model

On May 5, 2008, the Federation of State Medical Boards announced that:

> On May 3, the Federation of State Medical Boards' (FSMB) House of Delegates took the next steps in developing a model policy that will assist states in requiring physicians to demonstrate their continuing competence as a condition of re-licensure.
>
> At its annual meeting in San Antonio, the House of Delegates endorsed a recommendation for additional research into the impact of a model policy, developed and released in draft form earlier this year by a special committee, would have on state medical boards, licensed physicians and other stakeholder organizations. The draft policy requires physicians to take part in ongoing self-assessment and to demonstrate continuing competence in their areas of practice…
>
> The House of Delegates also approved five guiding principles for policy development:
>
> - Maintenance of licensure should support physicians' commitment to lifelong learning and facilitate improvement in physician practice.

- Maintenance of licensure systems should be administratively feasible, and should be developed in collaboration with other stakeholders. The authority for establishing MOL requirements should remain within the purview of state medical boards.

- Maintenance of licensure should not be overly burdensome for the profession and should not hinder physician mobility.

- The infrastructure to support physician compliance with MOL requirements must be flexible and offer a choice of options for meeting requirements.

- Maintenance of licensure processes should balance transparency with privacy protections.

See the full press release at: http://www.fsmb.org/index.html and the draft model policy at www.fsmb.org/m_mol.html.

CAC Supports Federation Maintenance of Licensure Initiative

CAC President and CEO, David Swankin, delivered the following remarks about the FSMB's proposed model before the Federation's Reference Committee on May 2, 2008:

Statement of David Swankin, Esq., President and CEO, Citizen Advocacy Center (CAC), to the FSMB Reference Committee, Commenting on Board Report of 08-03, "Assuring the Ongoing Competence of Licensed Physicians," and on the Final Report of the FSMB Special Committee on Maintenance of Licensure.

Good Morning:

The Citizen Advocacy Center (CAC) appreciates the opportunity to present these brief comments on the above-referenced documents now being considered by the reference committee…

For more than a decade, one of our most important program objectives has been to promote the creation of systems and processes designed to assure the public that health care professionals remain competent throughout their careers. We have published numerous reports and convened several national conferences to advance this goal. Indeed, we are convening a workshop on May 12 and 13, 2008 to facilitate an in-depth exploration of the most effective and least burdensome methods by which to demonstrate current competence. We are pleased that an FSMB representative will be attending that workshop.

FSMB and its special committee on maintenance of licensure are to be commended for the leadership they have displayed in moving forward in this area. FSMB, along with ABMS, AOA, and AOA BOS, have clearly recognized the need to assure the public of the current competence of physicians, and FSMB is ahead of most other regulatory board associations in making this a priority.

As CAC has pointed out repeatedly, the need to require health care professionals to periodically demonstrate their current competence has been widely recognized since the early 1960's. In our 2004 "Road Map to Continuing Competence Assurance," CAC called on health professional regulators and state legislatures to collaborate with health professional groups

and other interested parties to put in place a 5-step model addressing both lifelong learning and competency demonstration.

The model's five steps are:

Step One:	Routine Periodic Assessment
Step Two:	Develop a personal plan
Step Three:	Implement the personal plan
Step Four:	Document the personal plan
Step Five:	Demonstrate/evaluate competence.

Repeated in regular cycles, steps one through four are, in effect, a quality improvement program based on a system of lifelong learning. Step five is the quality assurance dimension. It is step five that helps assure the public that the lifelong learning program has, indeed, been successful. Again, we congratulate FSMB for incorporating the 5-step model in the Special Committee report and in the February 2008 report of the Board of Directors. That same leadership has been demonstrated by ABMS, AOA, and AOA BOS, and we applaud them as well.

We recognize that the FSMB Board of Directors is sensitive to the concerns of your member boards regarding implementation of the FSMB model. While CAC would like to see the FSMB model implemented on a fast track, we recognize the legitimacy of some of the concerns expressed by your member boards, and understand why you have chosen to take an extra year look into these concerns before moving to the implementation stage. Medical boards are not alone. Other professions have raised similar questions about the implementation of continuing competency requirements.

This is a major reason why CAC is convening the May 12 – 13, 2008, workshop on methods for assessing and demonstrating current competence. Among other things, we plan subject the various methods to the "APPLE" test:

- **A**dministratively feasible;
- **P**ublicly credible;
- **P**rofessionally acceptable;
- **L**egally defensible;
- **E**conomically affordable.

While we understand many of your member boards' concerns about the practicalities of implementing continuing competence or maintenance of licensure requirements, we are less sympathetic to the push back from some professional groups. The comments submitted by some of them contrast sharply with the position advanced by the American Nurses Association (ANA) in a 2007 draft position statement on Competence and Competency:

ANA believes that the public has a right to expect nurses to demonstrate competence throughout their careers… competence is definable, measurable, can be evaluated, and context determines what competences are necessary.

They also contrast sharply with the views of Lucien Leape and John Roman, who wrote in the January 17, 2008 Annals of Internal Medicine that "Physician performance failures are not rare and pose substantial threats to patient welfare and safety." They call on FSMB, ABMS, and JCAHO to collaborate on developing better methods for measuring performance, and to expand

programs for helping practitioners who are deficient.

I know that ABMS faced similar opposition from some professional associations when it developed and began to implement MOC requirements for its 24 member boards. Had ABMS listened to the nay-sayers, there would be no MOC in place. Instead, ABMS showed leadership.

Leadership is defined by Webster as "the successful resolution of problems through enlightenment and exhortation." FSMB showed leadership in the past, when, for example, it stood up against strong opposition from some professional organizations who opposed the USMLE #3. We urge the Federation to continue to show leadership in making meaningful demonstrations of current competence an integral part of maintenance of licensure.

The Special Committee has committed itself to developing recommendations that would strengthen relicensure requirements without significantly increasing the regulatory burden on the majority of practicing physicians. We believe they have met that test. It is no more an unacceptable regulatory burden periodically to demonstrate current competence than it is to demonstrate competence at the time of initial licensure. We urge the FSMB House of Delegates to continue on the path laid out by the Committee, accept the report, take the next 12 months to address the concerns of your member boards, and go forward with the implementation phase next spring at the 2009 Annual Meeting.

Physical Therapy Board Association President on Continuing Competence

Dargan Ervin, Jr., President of the Federation of State Boards of Physical Therapy wrote the following about the role of licensing boards in ensuring continuing competence in the Online* Federation Forum *(www.fsbpt.org/download/Forum):

> At our 2007 Annual Meeting, our Delegate Assembly made a commitment to a Comprehensive Continuing Competence Program. The continuing competence issue is also being addressed by the American Physical Therapy Association (APTA). Both organizations are looking at approaches to ensure that physical therapy practitioners are making efforts to remain competent. I believe that it is the fundamental right and responsibility of licensing boards to ensure that physical therapy practitioners remain competent throughout their work life. In addition, I think that both the Federation and the APTA have a role in helping the licensing boards ensure that their licensees are competent.
>
> I hope that we can find a way to work together to that end. APTA and the Federation can provide licensing boards with a variety of tools, education sessions and programs that boards can review and use. The goal of developing these tools is to provide boards with a spectrum or alternatives that they might not be able to develop with their own resources.
>
> Clearly, the day is coming when simply paying a licensure renewal fee and turning in a report of continuing education attended is not going to be enough to show that you are a competent practitioner. Licensing boards have an enormous responsibility because of their licensees' impact on patients' lives, and through the ripple effect, the lives of others. As individuals, we would expect healthcare providers for members of our family, or friends, or ourselves to be competent and also

work to ensure ongoing competence. Licensing board members, then, should find it reasonable that consumers in their state or jurisdiction expect the same. The Federation and its licensing boards should look at methods of ensuring continued competence, exploring means that are effective and reasonable. Hopefully, all licensees will understand and support these efforts, particularly if the licensing boards and the Federation focus on explaining why continuing competence is important and why it matters.

This is not to imply that the measurement of entry-level competence doesn't matter. Ensuring entry-level competence remains a priority for the Federation. In this day and age where cheating seems to be more the norm and not the exception, keeping up our efforts in exam security takes a great amount of effort and money. But it is worth it and we will continue our efforts to keep the NPTE secure. Why? Because it does matter.

I appreciate the work of our educators, diligently working to develop tomorrow's practitioners. I appreciate the current students who have so much to learn in so little time to prepare for entry into practice. I have a real appreciation for all licensees. And I appreciate the jurisdictional regulators that work to promote consumer protection. All of the work that all of the above do matters … it matters to the patients that depend on physical therapists and physical therapist assistants; they put so much trust in what physical therapy does.

So, in addition to remaining committed to ensuring entry-level competence, licensing boards and the Federation need to look for and be receptive to methods of demonstrating continuing competence in physical therapy. Why? Because it matters.

Virginia Nurses Address Continued Competence

Virginia Nurses Association Legislation Coordinator, Leslie Herdegen-Rohr, wrote about Nurses and Continued Competence in the February-March-April issue of Virginia Nurses Today. Excerpts of her article appear below:

> …In Virginia, nurses are the only health professional without a legal requirement for demonstrating continued competence. There is a reason for this. Other professions are required to have a specific number of hours of continuing education to renew their licenses, and the licensing boards audit a small portion of licensees to ensure that they comply with this requirement. But, does CE ensure continued competence? Are there other ways nurses can demonstrate that they remain competent and up-to-date to practice? Nurses aren't so sure; therefore, the Board of Nursing has been reluctant to require CE for relicensure…
>
> How, then, do nurses ensure that they remain competent? Most nurses take seriously the need to remain current and competent, and do so through professional credentialing, leadership activities, ongoing practice and on-the-job experience and learning, subscriptions to journals, and continuing education. Which of these is most effective, most cost-effective, and most objective, to ensure the continued competence the public expects?

…In plain terms, the question is how to assess knowledge, critical thinking, communication relationship abilities and performance skills at the time of relicensure. While all agree that this should be an important component of consideration for health professional licensure boards, the underlying disagreement is how to do it.

Let's look at each of the areas that could be used to evaluate continued, not initial, competence: professional credentialing, leadership activities, ongoing practice and on-the-job experience and learning, professional reading, and continuing education, as well as the question of retesting.

Professional Credentialing

Professional credentialing would include such things as an unencumbered license, specialty or advanced practice certification, post-licensure academic coursework, degrees or certificates. These criteria obviously are easy to measure accurately, and ensure that the relicensure applicant has proven to an academic institution, a credentialing body, or a licensing board that they have successfully completed the requirements. So, these would be good objective criteria, but all of them with the exception of an unencumbered license come with an additional cost—sometimes a substantial cost.

Leadership Activities

Leadership might include such things as participation in workplace committees, service with professional associations or state or local boards or committees, preceptorship, publications or presentations, or volunteer activities related to healthcare. The relationship between leadership activities and continued competence includes some areas where there clearly is a nexus (i.e. service on a quality assurance committee at work) and some areas that are grayer (i.e. whether service as the Treasurer of the Virginia Nurses Association adds to your professional competence). Obviously, the cost of these activities is minimal, but the measure of the quantity, quality and assurance of continued competence is less objective.

Ongoing Practice and On-the-Job Experience and Learning

There is no question that continuous good practice is one of the best assurances of continued competence. However, ongoing bad practice (i.e. repetition of inappropriate, substandard or just wrong practices) probably is closely associated with lack of competence. Because nurses most often function as part of a healthcare team, the latter is less likely to occur however, we all know of situations when it does. We also know of employers who stress on-the-job experience and learning, and offer opportunities for nurses to participate (or even require participation), we also know of employers who do not. So, while ongoing employment with its related opportunities is one of the least costly and least burdensome ways for a nurse to demonstrate continued competence, it is not necessarily reliable.

Professional Reading

There are few nurses who do not subscribe to professional journals or read them in libraries or elsewhere. There is no question that professional articles on such things as newly-developed protocols and techniques, new drugs, new standards of care are an important component of continued competence. But, objective measurement and proof of learning is absent, and there is no good way to measure it reliably. And, the cost of subscriptions is often high, or included in the cost of a membership which is also pricey. While there are ways to minimize this cost, they are significantly less convenient than a subscription, and therefore, nurses are less likely to take advantage of these written materials.

Continuing Education

This is the crux of the discussion. In state after state, for profession after profession, continuing education is the accepted measure of continued competence. But, in reality, is it a good measure, and do the benefits outweigh the costs? That is the question for nurses and other professionals in Virginia, in other states across the country, and for other professional organizations. It also is the question being discussed by the Attorney General Task Force and the Board of Health Professions.

During the 2007 session of the Virginia General Assembly, a bill was introduced to require RNs and LPNs to have met certain continuing education requirements as a condition for license renewal. The chief patron said he introduced the bill at the request of a nurse constituent who believes that nurses should have to meet the same requirements as other professionals, and that this measure of continued competence is appropriate. While other nurses disagreed about CE requirements, the VNA opted not to take a position, but asked the patron to consider deferring to the two groups looking at CE currently. He agreed, and withdrew the bill.

Absent a competing recommendation from one or both of the groups currently examining this issue, we can be certain that the bill will be back. And, we may well see that one or both of these groups recommends CE as the best way to, or one of the best ways, to ensure continued competence.

Continuing education is the most commonly used method to indicate continued competence for other professions in Virginia and across the country. It is easy to objectively assess and document, making it a measure that can be used well by licensing boards as an indicator of continued competence for relicensure.

But how does the cost-benefit analysis stack up? Over the years, a number of studies have produced results to demonstrate that CE does not substantially improve patient outcomes. It is widely believed that this is due to the passive learning nature of most CE courses and the fact that professionals have the ability to sign in for CE credits and not attend the educational session, although there is no empirical evidence to support these hypotheses. Yet, a February, 2007 literature review by the Johns Hopkins Evidence based Practice

Center: the literature overall supported the concept that CME was effective, at least to some degree, in achieving and maintaining the objectives studied, including knowledge (22 of 28 studies), attitudes (22 of 26), skills (12 of 15), practice behavior (61 of 105), and clinical practice outcomes (14 of 33). So, there is no conclusive evidence on efficacy of CE.

The Attorney General's Regulatory Review Commission is looking at a study in progress that we believe will demonstrate the cost of CE is high, particularly when tuition and lost income both are considered. If this study should produce the results we expect, it will be an interesting analysis as to whether continuing education is a cost-effective way to measure continued competence.

One More Option: Retesting

One of the other options sometimes discussed as a method to ensure continued competence is retesting. Often, those who propose retesting are not specific about what test must be retaken for license renewal, although some commonly assume it is the exam for initial licensure. Few professionals believe this is appropriate. The exam for initial license for all health professionals is broad, reflecting their education and training. Most professionals go on to work in a specific field and may never confront many of the situations they learned during their educational careers. Alternatively, many of the certification bodies require periodic retesting only in the specialty area, and these exams could be used, although if certification were required, it would significantly increase the cost for health professionals, including nurses.

Summary

All nurses would agree that continued competence is a vital part of safe and effective nursing practice. Nurses also generally would agree that some way to ensure continued competence at the time of license renewal is important. Yet, it appears that there is not agreement on the best way for the Board of Nursing to accomplish this goal.

VNA will deliberate its position on continuing competence as the groups studying this move forward. As we do so, we welcome any thoughts that you might have. Just send them along to our Executive Director, Susan Motley, at smotlev@virpinianurses.com.

Read the entire article at:
http://nursingald.com/uploads/newsletters/VA042008.pdf

SPOTLIGHT

Louisiana Medical Board Reports on Rules and Legislation

This Quarter's Spotlight shines on the Louisiana State Board of Medical Examiners for periodically providing "timely reminders" to licensees and others about rules, policy statements, opinions, and legislation. The board's October 2007 ***NewsletteR*** reports on board policies and opinions regarding office-based dispensing, ear stapling, internet prescribing, and the use of the term "board certified." In addition, the issue reports on legislation passed in the prior year affecting impaired health

professionals, podiatry scope of practice, doctor shopping, respiratory therapy, and acupuncture. "We hope," writes the board president, Kweli Amusa, MD, "that you will take the time to review this information to the extent that it relates to your practice."

We commend the board for using its newsletter for this valuable educational purpose and recommend that other boards which do not already do so adopt the same practice.

MEDICAL ERRORS AND PATIENT SAFETY

CAC Joins in Comments on Proposed Patient Safety and Quality Improvement Rule

Editorial Note: CAC joined the Center for Medical Consumers in sending the following comments to the Agency for Healthcare Research and Quality on proposed rules to implement the Patient Safety and Quality Improvement Act of 2005:

April 10, 2008

Center for Quality Improvement and Patient Safety
Attention: Patient Safety Act NPRM Comments
Agency for Healthcare Research and Quality
540 Gaither Road
Rockville, MD 20850

RE: Patient Safety and Quality Improvement Proposed Rule

Dear Administrator:

Thank you very much for the opportunity to comment on the U.S. Department of Health and Human Services' (HHS) proposed rule on Patient Safety and Quality Improvement, 42 CFR Part 3 (February 12, 2008) (Agency for Healthcare Research and Quality and the Office for Civil Rights, HHS, RIN 0919 – AA01).

As organizations committed to fostering quality and safety improvement in health care, we note with interest the release of proposed rules to implement the Patient Safety and Quality Improvement Act of 2005 (PL 109-41). We continue to believe that this legislation as written falls short in many ways of an appropriate federal response to the crisis in patient safety that has been documented as pervasive throughout the U.S. healthcare system. However, since it is law, we also believe that the proposed rule-making provides an opportunity for improving on the rules so as to better serve the public interest. At a time when preventable medical errors kill approximately 180,000 Americans every year, timely and appropriate implementation of the law is essential.

To that end we have the following comments:

Our work during the drafting of the Patient Safety and Quality Improvement Act and our comments on the proposed rule are guided by the following principles:

- While a certain level of confidentiality and protection from legal discovery is needed to encourage the voluntary reporting of medical errors and near misses, this protection should not shield information from a patient that would otherwise have access to it. We believe the law struck the right balance on this issue, and applaud the proposed regulations' adherence to this balance.

- An effective voluntary reporting system depends on having qualified, independent entities collect and analyze the data reported by providers. The patient safety rule should include a rigorous certification process for patient safety organizations, evaluation of the qualifications and operations of these organizations, including the ability to maintain the privacy of identifiable patient information and the setting of clear objectives for use of the information collected. We believe that this is only meaningful if there is a requirement for annual random field audits of an appropriate percentage of certified patient safety organizations. Audit failures should prompt a review of certification status and decertification if appropriate. Any process for certifying patient safety organizations should also protect against conflicts of interest.

- Public reporting is a powerful incentive for quality improvement, and the patient safety rule should not undermine it. Any confidential reporting to patient safety organizations should preserve the reporting of performance information that increasingly has been required by public and private purchasers, states, and accrediting organizations.

- Patients should be able to trust that their personal health information will be kept confidential, and rigorous policies and procedures should be in place to protect the privacy and security of their individually identifiable health information.

Specific Comments

PSO Requirements and Agency Procedures

We are concerned that the proposed regulations do not provide a sufficient system of oversight for new and existing PSOs. As proposed, entities could be certified and recertified as PSOs with minimal review or regulation by the federal government.[1] We believe the Agency for Healthcare Research and Quality (AHRQ) should instead require entities wishing to be PSOs to apply to the agency and demonstrate their ability to meet the statutory and regulatory requirements.

Further, AHRQ should establish a more rigorous process for recertification. As proposed, the regulation simply requires a PSO to attest that it "is performing and will continue to perform" the requirements related to patient safety activities and governance.[2] We believe AHRQ should engage in ongoing review and assessment of the work of the PSOs in order to ensure that they are effectively engaging in the eight required patient safety activities and meeting the contractual and governance requirements of the statute.

Most importantly, we believe AHRQ has an important responsibility to collect relevant data and engage in a regular analysis of whether the collective work of the PSOs is actually reducing medical errors and improving the quality of care delivery in our health care system. We encourage adding a provision to the final rule delineating such a role for AHRQ.

[1] 73 Fed. Reg. 8112, 8173 (Feb. 12, 2008).
[2] *Id*. at 8127.

Standardized Data Collection

We applaud the proposed regulations' provisions to ensure that AHRQ is providing PSOs with ongoing guidance on the formats and definitions needed to ease the aggregation of patient safety work product data.[3] It is critical that the information collected by the PSOs be aggregated and analyzed so that problem areas can be quickly identified and priorities for action developed. We agree with the proposed rule's designation of the National Quality Forum (NQF) as the entity to set priorities for data collection, collect input regarding common formats, and solicit technical assistance to maintain existing common formats.[4] NQF has a strong track record of standardizing a patient safety taxonomy, and is well equipped to take on this responsibility.

HIPAA Privacy Rule

We believe implementation of the Patient Safety and Quality Improvement Act should not result in weakening the existing rules protecting patients' privacy or expose patients to additional security risks. We applaud the proposed rule for acknowledging the intersection between the Patient Safety regulations and the HIPAA Privacy Rule, and indicating clearly that PSOs would be considered "business associates" of covered entities under the Privacy Rule. That said, we have a few specific comments:

Impermissible uses or disclosures
The preamble to the proposed rule requests comment on whether PSOs should be required to notify the organizational source of patient safety work product if the information shared has been impermissibly used or disclosed.[5] We believe that such a notification should be required in order to ensure that patient safety work product that includes protected health information (PHI) is treated consistently with other health care data that includes PHI.

We also urge you to clarify in the final rule that HHS has the authority to levy separate fines under both the HIPAA Privacy Rule and the Patient Safety Rule. The fines at issue are not onerous, and pale in comparison to the potential harm suffered by an individual whose sensitive medical information is wrongfully disclosed. Where both statutes have been violated, HHS should be able to maximize the enforcement tools at its disposal to penalize bad behavior and ensure that PSOs are taking every precaution to protect patients' medical information.

Compliance with the HIPAA Privacy Rule
We recognize that data sharing between PSOs may be necessary to conduct meaningful analyses for quality improvement. However, when such data sharing includes PHI, it increases the risk to patients that sensitive medical information would be wrongfully disclosed or breached. We therefore support the provisions of the proposed rule that clarify that the limited data set standard of the HIPAA Privacy Rule (45 CFR 164.514(e)) applies to the sharing of patient identifiable data between PSOs.[6]

The preamble requests comment on whether the provision permitting the disclosure of PHI for health care operations in the HIPAA Privacy Rule (45 CFR 164.506) should be amended to conform to the patient safety work product disclosures for the patient safety activities described in the proposed rule.[7] We believe the HIPAA Privacy Rule should be modified to reference patient safety activities for two reasons: first, so that providers fully understand their obligations

[3] *Id*. at 8129.
[4] *Id*.
[5] *Id.* at 8126.
[6] *Id*. at 8146.
[7] *Id.* at 8147.

under both rules; and second, so that it is clear that the "minimum necessary" requirement of the Privacy Rule applies to disclosures of patient safety work product, and that the limited data set standard applies to disclosures between PSOs.

We thank you for the opportunity to comment on the proposed regulations to implement the Patient Safety and Quality Improvement Act.

Sincerely,

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CHEMICALLY DEPENDENT PRACTITIONERS

States Revisit Programs for Impaired Practitioners

Several states are taking another look at licensing-board sponsored programs for impaired health care practitioners. Most prominently, the Medical Board of **California** voted earlier this year to discontinue its diversion program for **California** doctors and not to replace it. The program ceases to exist on June 30, 2008.

The state medical association wants some sort of alternative program for doctors and is supporting legislation to recreate a diversion program with more consistent standards for handling doctors who have problems with substance abuse or mental health. The bill would instruct the Department of Consumer Affairs to develop guidelines for diversion programs for all health care practitioners in the state. Presently, the boards for nurses, dentists, pharmacists, physical therapists, veterinarians, osteopaths, and physician assistants outsource their diversion programs to a company headquartered in Virginia.

The **Arizona** medical board's diversion program was the subject of an expose in the ***Phoenix New Times*** on March 6, 2008 (www.newtimes.com). Reporter, John Dickerson writes that it took the medical board three years to discover that a graduate of its diversion program had relapsed, with fatal consequences for at least one patient. The board failed to expose the doctor to drug tests as part of its investigation of several complaints against the doctor.

The ***New Times*** investigators looked at the records of 50 chemically dependent doctors over a five year period and found that 45 had relapsed – 15 of whom relapsed after the board stopped monitoring them. This fact, Dickerson writes, raises questions about whether five years of monitoring after completing of the diversion program is sufficient. He also questions the policy of protecting the confidentiality of doctors who participate in the program.

Dickerson also quotes cosmetic surgeon Stephen Locnikar who wrote a book about his experiences practicing in **Arizona** while addicted. Locnikar believes graduates of impaired professionals programs should be monitored not just for five years, but for the duration of their practice.

In **Oregon,** it is the board of nursing's diversion program that continues to attract the attention of the legislature. Two years ago, a ***Portland Tribune*** investigative report about the nursing board's discipline and diversion programs resulted in the resignation of the board's executive director

and other staff changes. According to an ***Associated Press*** report dated April 14, 2008, the newly appointed executive director, Holly Mercer, found a situation even worse than she anticipated. Large numbers of nurses in the diversion program, Mercer said, were not meeting requirements, such as appearing for urinalysis tests or reporting to monitors. The legislator in charge of the House Health Care Committee has promised to introduce legislation in 2009 that would establish better oversight of the boards, adjust the balance between public and licensee members, and centralize some services.

Editorial Note: In addition to investigative reports such as these about impaired professionals programs, an article in the online magazine Men's Health by Christopher McDougall alleges there is an "epidemic" among anesthesiologists of addiction to the drugs they use in the operating room. McDougall interviewed Dr. Mark Gold, a psychiatry professor at the University of Florida who reviewed 20 years of records of the Physicians Recovery network and discovered that anesthesiologists were over-represented in the sample by 500%. The full article can be found at: http://www.menshealth.com/cda/article.do?site=MensHealth&channel=health&category=doctors.hospitals&conitem=d7a4dfaa4d41e010VgnVCM20000012281eac.

POLITICS AND REGULATORY BOARDS

Editorial Note: We've recently noticed an unusual incidence of licensing boards finding themselves in the middle of political brouhahas. Three examples are explored here: the Kansas Board of Healing Arts, the Nevada Board of Medical Examiners, and the California Board of Chiropractic Examiners.

Kansas Board Executive Resigns Under Pressure

Late in 2007, the Kansas Board of Healing Arts was the subject of a critical audit by the Legislative Division of Post Audit (www.kslegislature.org/postaudit). In the aftermath, legislation was proposed to speed the board's disciplinary processes and expand the board's enforcement tools, allowing it to take action after a single finding of negligence rather than waiting for three instances.

The legislature and the press kept the pressure on the board and its staff into the spring of 2008, even though the board agreed to and acted on many of the audit's recommendations. Prominent in the criticism of the board was the case of Stephen Schneider, accused of operating a "pill mill" and contributing to the deaths of dozens of patients. The board began legal proceedings against Schneider in 2006, but put the case on hold for nearly a year. Schneider's license was ultimately suspended after a federal grand jury indicted him. The board contended that federal prosecutors asked them to put the case on hold pending federal action, something federal officials denied.

In late March, both houses of the legislature passed resolutions (SR 1846 and HR 6025) seeking changes in the board staff. On April 2, 2008, Executive Director Laurence Buening announced his resignation "in the best interest of the board." Buening, who had been with the board since 1984 and executive director since 1992, told ***Associated Press*** reporter John Hanna that the state senate debate on its resolution was a key factor in his decision to resign. Republican State Senator Susan Wagle and other vocal abortion opponents have criticized Buening and the board for being lax in regulating abortion providers. Speaking at the hearing, Wagle accused the

board and its staff of "standing over in that agency in a pool of innocent human blood," according to Hanna. Singling out Buening, abortion opponents pointed out that his wife works for Governor Sibelius, a strong supporter of Choice.

Legislation to strengthen the board's powers was passed and sent to the governor on May 2, 2008. Buening and the board's chief counsel, Mark Stafford, will depart by July 1, 2008.

Nevada Medical Board and Elected Officials Spar Over Fallout from Hepatitis C Outbreak

In February, 2008, six patients were found to have acute hepatitis C after undergoing procedures at Desert Shadow Endoscopy Center which was re-using syringes. Approximately 40,000 patients who patronized the clinic between March 2004 and January 11, 2008 were urged to be tested for hepatitis B and C and HIV. Newspapers and the District Attorney investigated, elected officials called for hearings, some patients sued, and the Nevada Board of Medical Examiners divulged that it had initiated an investigation of the physicians associated with the clinic.

Medical board executive director Tony Clark told Paul Harasim and Annette Wells of the ***Las Vegas Review Journal*** he thought the board might not be able to suspend the physicians because by the time the situation became public, the clinic had corrected the situation. Still, he said, the board would carefully review the health department's investigative report.

In March, the county suspended the clinic's business license. Five nurses who worked at the clinic surrendered their licenses to the nursing board. The State Board of Licensure and Certification fined the clinic $3,000 and assured the public that all deficiencies had been corrected. The Governor authorized the department of health to adopt emergency regulations requiring the staff of all clinics to demonstrate competence in administering medications.

At the suggestion of a legislator, Tony Clark said he would suggest the medical board follow the lead of the nursing board and request that the 14 physicians who worked at the clinic surrender their licenses. Only one of the physicians had a previous complaint on record – for false advertising.

Investigators found that the inspectors had failed to inspect nearly half of the state's ambulatory surgical centers in the past six years. Governor Gibbons refused to support more inspections, warning of "overkill."

Instead, he threatened to take legal action to remove three members of the medical board if they declined to resign voluntarily. He wanted them removed because of close personal and business relationships with Dr. Dipak Desai, majority owner of the Endoscopy Center and the physician with the false advertising fine on his record. Gibbons also asked for Tony Clark's resignation. Clark alleged this was retaliation for Clark having forced Gibbons to retire as Air Guard Vice Chairman in 1994.

Neither Clark nor the board members agreed to resign, but the three board members recused themselves from and proceedings involving the clinic. Gibbons did manage to have the head of the Bureau of Licensure and Certification removed from her position. Clark accused the governor of using the board as a "scapegoat for his ineptitude" in handling the hepatitis C crisis. Former Governor Kenny Guinn publicly disagreed with Gibbons' attempt to remove the board members and staff. Senator John Ensign asked the governor to consider appointing an

interim committee of the board to handle the clinic matter. Governor Gibbons ended his call for resignations on March 28 and announced he would appoint three temporary board members to handle the case.

In April, state legislators became more vocal, criticizing the medical board for the slowness of its investigation and for its refusal to release complaints about Dr. Desai to the metropolitan police. Legislators were considering several ways to overhaul the medical board. One suggestion was to appoint a public screening panel to narrow down the candidates the governor could consider for appointment. Another idea was to establish a majority of public members on the board and to require that the board president and executive director be public members.

At press time (late June), the board's investigation continues and a hearing for Dr. Desai has been scheduled for September 8, 2008. On a positive note, the medical board voted to post more information about doctors, including malpractice histories, on the board's website.

California Chiropractic Board Charged with Breaking Laws

The California Board of Chiropractic Examiners attracted lots of attention in 2007 when Governor Arnold Schwarzenegger appointed to the board some friends from his bodybuilding days who publicly stated their intention to pull back what they viewed as excessive regulation of chiropractors. In March, 2007, the newly composed board fired its executive director, allowed the new board president (a Schwarzenegger friend) to assume the executive director duties, ejected a deputy attorney general from a meeting, and took other controversial actions.

Defending his appointments, the governor told reporters that "We don't give them directions. What is important is that the chiropractic board represents the chiropractors. And each board represents their profession." Schwarzenegger did force his friend, Richard Tyler, to give up the executive directorship.

A year later, in March 2008, a state audit concluded that the chiropractic board had broken several state laws. It failed to comply with the state's open meetings law and the requirement that board members submit financial reports, and also allowed staff to approve or deny licenses. The auditors also faulted the board for taking too long to process complaints and take disciplinary action. According to the state auditor:

> Our review of the State Board of Chiropractic Examiners' (chiropractic board) enforcement, licensing, and continuing education programs and the role and actions of the chiropractic board members revealed the following:
>
> - Board members' lack of understanding about state laws related to their responsibilities as board members, including the Bagley-Keene Open Meeting Act, resulted in some violations of state law and other inappropriate actions.
>
> - The chiropractic board did not ensure that its designated employees, including board members, complied with the reporting requirements of the Political Reform Act of 1974.

- Board members inappropriately delegated responsibility to approve or deny licenses to chiropractic board staff.

- The chiropractic board has not developed comprehensive procedures, such as the length of time it should take to process complaints and, as a result, staff do not always process complaints promptly.

- The board's weak management of its enforcement program may have contributed to inconsistent treatment of complaints as well as unreasonable delays in processing.

- The chiropractic board does not ensure that staff process priority complaints promptly. Of 11 priority complaints we reviewed staff took from one to three years to process nine of them.

- Although the chiropractic board's regulations require that it establish chiropractic quality review panels, it has never complied with its regulation.

- The chiropractic board has insufficient control over its licensing and continuing education programs.

Read the audit report at: http://www.bsa.ca.gov/reports/highlights.php?id=560.

ROLE OF THE PUBLIC MEMBER

Legislator Speaks About Board Members and Board Service

Editorial Note: The following account of remarks by Tennessee House Majority Leader Gary Odom at the January 2008 FARB (Federation of Associations of Regulatory Boards) Forum are reprinted from ASWB Association News (Feb, 2008). CAC News & Views was pleased to read that there was push-back from the audience against his comments about the value of public members. We also take exception to Odom's enthusiasm about the ties of licensee members to their professional associations, as we think close ties to a professional association can produce a tendency to think first of the interests of the profession as opposed to the public interest. We applaud him for recognizing scope of practice as an important and complex issue, but hope boards can find more evidence-based bases for resolving scope disputes than insurance premiums and the relative dissatisfaction of the parties of interest.

According to Tennessee House Majority Leader Gary Odom, service on a regulatory board is hard and important work – sometimes more hard and important than board members anticipated when they took the positions. "(New board members) think they're going to have a good little something on their resumes," he said, "and they really don't know what they are getting into."

…Though his topic was titled, "A Legislator's Perspective," Odom focused most of his remarks on the importance of board members developing a thorough understanding of their responsibilities. And, in Odom's opinion, those responsibilities begin with a board member's duty to come to grips with the realities of board service.

While they may accept an appointment to a board with thoughts of minimal responsibilities, big per diems, and short agendas dancing in their heads, board members are soon faced with some cold hard realities. "They don't realize the expense," said Odom, as an example. The bottom line, according to the legislator, is that "they can't be wimps. They need to make tough decisions.

Unlike some in the public sector who are wary of fox-guarding-the-henhouse characterizations, Odom is a believer in the value of professional members on a board, as well as in strong ties to the relevant professional associations. Having served as the executive director of the Tennessee Optometric Association for several years, Odom says that the experience reinforced his belief that professional groups can play a big part in helping regulatory boards accomplish their missions. "Protection of the public should not be considered inconsistent with what an association does," he said.

From a legislator's perspective, Odom explained, the best boards are the ones in which all members and support staff have a clear idea of not only the limits of their power as a board, but the roles and responsibilities within the board itself. Big issues such as statutory limits and rulemaking authorities are crucial, he said, but so are the smaller elements, such as the seemingly mundane issues around meeting procedures.

Odom warned attendees that disciplinary hearings could bring what he described as a "major, major issue" into focus: namely, "imbalance" that can occur between the attorneys representing the board and the lawyers hired by the respondent. Often, the board attorneys are overworked and assigned to a range of cases spanning multiple professions, while the respondent's representative can concentrate more time and energy on dismantling what might initially appear to be a solid case.

The representative's presentation was not without controversy, however. Near the end of his talk, Odom underscored his belief that boards should be made up of people who are intimately involved with the profession being regulated. Then, in a statement running counter to what may be prevailing opinion, Odom told the audience, "I'm not a big fan of citizen members." He said that in his experience, public members were not well-equipped to do the job of regulator. "I just don't think they contribute very much," Odom said. "Citizen members don't even show up (to meetings)." The remarks were met with critical responses from some attendees during the question-and-answer session that followed his presentation.

In addition to responding to several challenges about this opinion on public members, Odom also provided attendees with various approaches to untangling scope-of-practice debates among related professions. Odom suggested reviewing malpractice premiums in neighboring jurisdictions with scopes similar to ones being proposed as one way to get a bead on how to divide the turf, but warned the audience that in the end, the best sign that an effective compromise has been reached is when "nobody is happy" with the result.

IN-DEPTH

Experts Recommend Continuing Education Reforms

Editorial Note: The Josiah Macy Jr. Foundation convened a conference in November 2007 to examine issues associated with continuing professional education. The conference participants included healthcare practitioners, educators, hospital and health plan administrators, accreditors, and public policy makers. The premise at the conference is that continuing education (CE) plays a vital role in professional development – arguably more important than ever because of the pace of change in health care delivery. Because of this, it is all the more essential that recognized deficiencies in CE are corrected and that CE providers adopt state-of-the-art educational methods.

Readers of* CAC *News & Views are aware of CAC's emphatic support for the adoption of requirements that practitioners demonstrate their current competence as a condition of license renewal or re-certification. You are aware also that we have joined most other observers in challenging entities that rely exclusively on counting mandatory CE credit hours as a surrogate for current competence. This is not to say that CAC fails to appreciate the very important contribution that well-designed CE programs can – and must – play as part of a comprehensive program of professional development and demonstrations of current competence. Therefore, CAC congratulates the Josiah Macy Jr. Foundation for convening this conference which generated important recommendations for strengthening professional CE programs.

We do need to express our disappointment, however, that the conference participants appear to consider CE, albeit vastly improved and far more broadly construed, to be the only vehicle for maintenance of certification and licensure. CAC believes strongly that CE should be part of a package of methods for demonstrating current competence. The ABMS boards, for example, are developing packages that include testing, peer review, and other methods for professional development and demonstrating competence, along with CE.

We are also disappointed that the participants chose to look primarily to the professions and academic centers to implement changes in CE. We would prefer to see participation by all stakeholders, including at least regulators and consumer/patient organizations. What follows are excerpts from the Conference Summary prepared by Chairman Suzanne W. Fletcher, M.D., M.Sc. of Harvard Medical School. A longer report from this important Conference and commissioned background readings can be found at http://www.josiahmacyfoundation.org/ .

Continuing education (CE) of health professionals is essential to the health of all Americans. With accelerating advances in health information and technology, physicians, nurses and other health

professionals must maintain and improve their knowledge and skills throughout their careers in order to provide safe, effective and high quality health care for their patients.

Yet continuing education in the health professions is in disarray. Over the past decade, both professional and lay reports have identified multiple problems. CE, as currently practiced, does not focus adequately on improving clinician performance and patient health. There is too much emphasis on lectures and too little emphasis on helping health professionals enhance their competence and performance in their daily practice. With Internet technology, health professionals can find answers to clinical questions even as they care for patients, but CE does not encourage its use or emphasize its importance. And, while studies show that inter-professional collaboration, teamwork and improved systems are key to high quality care, accrediting organizations have not found ways to promote teamwork or align CE with efforts to improve the quality of health systems.

Another significant problem is the growing link between continuing education and commercial interests. In 2006, the total income for accredited CE activities in medicine was $2.4 billion. Commercial support from pharmaceutical and medical device manufacturers accounted for more than 60 percent, about $1.45 billion, of the total…

Although much of the conference discussion was relevant to the continuing education of all health professionals, participants focused on accredited CE for medicine and nursing. They acknowledged that much professional learning takes place informally and outside accredited formats.

Conference themes were interrelated, for the methods used for continuing education are influenced both by the means of financial support and by mechanisms for accreditation. Unfortunately, participants found, current systems of CE do not meet the needs of health professionals as well as they should:

- Too much CE relies on lecture format and counts hours of learning rather than improved knowledge, competence and performance.

- Too little attention is given to helping individual clinicians examine and improve their own practices.

- Insufficient emphasis is placed on individual learning driven by the need to answer the questions that arise during patient care.

- CE does not promote inter-professional collaboration, feedback from colleagues and patients, teamwork, or efforts to improve systems of care, activities that are key to improved performance by health professionals.

- CE does not make adequate or creative use of Internet technology, which can help clinicians examine their own practice patterns, bring medical information to them during patient care, and aid them in learning new skills.

- There is too little high-quality scientific study of CE.

Participants warned that health professions, especially medicine, threaten the ethical underpinnings of professionalism by

participating in a multi-billion dollar CE enterprise so heavily financed by commercial interests. This arrangement, which evolved over the years, distorts continuing education… Independent judgment of how best to care for patients is compromised. Bias, either by appearance or reality, has become woven into the very fabric of continuing education. The professions themselves must right this wrong.

In a free-market system, commercial entities, such as drug and device manufacturers, have a clear responsibility to shareholders to gain market advantage and generate a profit, while health professionals have a moral responsibility to provide safe, high quality care for their patients, based on valid scientific findings. The two responsibilities are fundamentally incompatible… (A)n objective and neutral assessment of clinical management options is precisely what is needed in continuing education. Participants emphasized that, regardless of the financial impact on for-profit companies, patient care must be based on scientific evidence and commercial interests should not determine the topics or content of CE. Because of these underlying ethical issues, participants concluded that the commercial entities that manufacture and sell health care products should not provide financial support for the continuing education of health professionals…

Despite recent changes in CE accreditation to reduce commercial influence, the problem persists, and organizations with little professional expertise in health care, and supported almost entirely by commercial interests, provide accredited continuing education. At the same time, accrediting groups require all organizations providing CE to go through laborious, bureaucratic procedures to document that no inappropriate influence has occurred.

Participants pinpointed another serious failure with current accreditation mechanisms. At a time when inter-professional collaboration, teamwork, and improvement of systems are key to high quality health care, accrediting organizations for the various health professions still work in silos. Rather than promoting inter-professional collaboration and education, regulations and procedures for accreditation make inter-professional collaboration difficult. And, while systems of care have a major impact on the quality of health care delivered by clinicians, accrediting organizations have been slow to align their CE activities with quality improvement efforts by systems of care.

Participants identified a set of principles they believe should underlie and guide continuing education of the health professions:

- Integrate continuing education into daily clinical practice.
- Base continuing education on the strongest available evidence for practice.
- Minimize, to the greatest extent possible, both the reality and the appearance of bias.
- Emphasize flexibility and easy accessibility for clinicians.
- Stress innovation and evaluation of new educational methods.
- Address needs of clinicians across a wide spectrum, from specialists in academic health centers to rural solo practitioners.

- Support inter-professional collaboration.

- Align continuing education efforts with quality improvement initiatives at the level of health systems…

CONCLUSIONS

Continuing Education and the Public

The quality of patient care is profoundly affected by the performance of individual health professionals.

The fundamental purposes of continuing health professional education (CE) are:

- To improve the quality of patient care by promoting improved clinical knowledge, skills and attitudes, and by enhancing practitioner performance.

- To assure the continued competence of clinicians and the effectiveness and safety of patient care.

- To provide accountability to the public.

CE fulfills a critically important, indeed essential, public purpose. Given the accelerating pact of change in clinical information and technology, CE has never been more important.

Responsibilities of individual professionals, professional teams and health systems

Maintaining professional competence is a core responsibility of each health professional, regardless of discipline, specialty or type of practice.

The individual clinician has been the principal unit of accountability for performance in the healthcare delivery system. Given that the performance of health systems also profoundly affects patient care, CE fails to take into account systems of care.

Effective patient care increasingly depends on well-functioning teams of healthcare professionals. Therefore, CE must address the special learning needs of collaborating teams.

Quality improvement efforts and CE activities overlap and ideally are mutually reinforcing.

CE Methods

Traditional lecture-based CE has proven to be largely ineffective in changing health professional performance and in improving patient care. Lecture formats and employed excessively relative to their demonstrated value.

Professional conferences play an important role in CE by promoting socialization and collegiality among health professionals. Health professionals have the responsibility to help one another practice the best possible care. Meeting together provides opportunities for cross-disciplinary and cross-generational learning and teaching.

Practice-based learning and improvement is a promising CE approach for improving the quality of patient care. Maintenance of certification programs (in which clinicians review the care they actually deliver in their own practices, compare the results with standards of excellence and create a plan for improvement) and maintenance of licensure programs are moving CE in this direction. Currently, most CE faculty are insufficiently prepared to teach practice-based learning.

Information technology is essential for practice-based learning by:

- Providing access to information and answers to questions at the time and place of clinical decision-making (point-of-care learning).

- Providing a database of clinician performance at the individual and/or group practice level, which can be compared to best practices and used to make plans for improvement.

- Providing automated reminder systems.

Financing CE

The majority of financial support for accredited CME, and increasingly for CNE, derives directly or indirectly from commercial entities…

Commercial support for CE:

- Risks distorting the educational content and invites bias.

- Raises concerns about the vows of health professionals to place patient interest uppermost.

- Endangers professional commitment to evidence-based decision making.

- Validates and reinforces an entitlement mind-set among health professionals that CE should be paid for by others.

- Impedes the adoption of more effective modes of learning.

No amount of strengthening of the "firewall" between commercial entities and the content and processes of CE can eliminate the potential for bias.

Academic health centers and other healthcare delivery systems are not sufficiently attentive, either to their roles in planning, providing, and assessing CE or to their responsibilities in managing their own conflicts of interest and those of individual faculty and administrators when paid by commercial interests for CE teaching.

Accrediting CE

Current accrediting mechanisms for CE are unnecessarily complex yet insufficiently rigorous… With the increasing need for inter-professional collaboration, accrediting bodies of the various health professionals need closer working relationships.

RECOMMENDATIONS

CE Methods

The CE enterprise should shift as rapidly as possible from excessive reliance on presentation/lecture-based formats to an emphasis on practice-based learning.

New metrics are needed:

- To assess the quality of CE. These metrics should be based on assessment of process improvement and enhanced patient outcomes.

- To identify high-performing healthcare organizations. The possibility of awarding CE credit to individual health professionals who practice in such organizations should be explored.

- To automate credit procedures for point-of-care learning.

Federal and state policymakers should provide financial support for the further

development of information technology tools that facilitate practice-based learning…

The responsibility for lifelong learning should be emphasized throughout early, formal stages of education in all health professions…

A national inter-professional CE Institute should be created to advance the science of CE. The Institute should:

- Promote the discovery and dissemination of more effective methods of education health professionals over their professional lifetimes and foster the most effective and efficient ways to improve knowledge, skills, attitudes, practice and teamwork.
- Be independent and composed of individuals from various health professions.
- Develop and run a research enterprise that encourages increased and improved scientific study of CE.
- Promote and fund evaluation of policies and standards for CE.
- Identify gaps in the content and processes of CE activities.
- Develop mechanisms needed to assess and fund research applications from health professional groups and individuals.
- Stimulate development and evaluation of new approaches to both intra- and inter-professional CE, and determine how best to disseminate those found to be effective and efficient.
- Direct attention to the wide diversity and scope of practices with special CE needs, ranging from highly technical specialties on the one hand to solo and small group practices in remote locations, on the other.
- Acquire financial resources to support its work and provide funding for research. Possible funding sources include the Federal government, foundations, professional groups, and corporations…

CE Financing

Accredited organizations that provide CE should not accept any commercial support from pharmaceutical or medical device companies… A five-year "phase-out" period should be allowed to meet this recommendation.

The financial resources to support CE should derive entirely from individual health professionals, their employers…, and/or non-commercial sources

Faculty of academic health centers should not serve on speakers' bureaus or as paid spokespersons for pharmaceutical or device manufacturers. They should be prohibited from publishing articles, reviews and editorials that have been ghostwritten by industry employees.

CEW Accreditation of Providers

Organizations authorized to provide CE should be limited to professional schools with programs accredited by national bodies, not-for-profit professional societies, health care organizations accredited by the Joint Commission, multi-disciplinary practice groups, point-of-care resources, and print and electronic professional journals.

Existing accrediting organizations for continuing education for medicine (the Accreditation Council for Continuing Medical Education) and nursing (the American Nurses Credentialing Center) should meet and within two years develop a vision and plan for a single accreditation organization for both nursing and medicine. The new organization should incorporate the guiding principles for CE and the recommendations laid out in this report where relevant. The American Academy of Nursing and the Association of American Medical Colleges should convene the two accrediting bodies for this purpose.

Academic health centers should examine their missions to determine how to strengthen their commitment to CE. They should help their faculty gain expertise in teaching practice-based learning and incorporate information technology, simulations and interactive scenarios into their CE activities.

LETTERS

Dear **CAC *News & Views***:

Cypress Creek Hospital in Houston advertises as a specialty psychiatric hospital. It has come to my attention that for some time now, non-psychiatric physicians have been providing admission evaluations at the facility. Recently, a group of primary care physicians was hired to carry out evaluations to determine if someone should be admitted or not. These primary care physicians are not trained as specialists in psychiatry. From a consumer/patient standpoint, it seems reasonable to me that when someone presents to a psychiatric hospital for an evaluation – one which may lead to an imposition upon their civil liberties (i.e., commitment) – that they should be evaluated by someone specially trained (or in training) in that field. I think it is misleading to patients/consumers who present for help to be evaluated by a doctor who is actually an ob/gyn or internal medicine specialist – not a psychiatrist. Who would think to question a doctor's specialty training in a specialty hospital? Mental health patients requiring frequent hospitalization already struggle enough to advocate for themselves, and when they DO speak out they are rarely taken seriously. Furthermore, while it may not be illegal to carry out such evaluations, I think it is clearly unethical and marginalizes an already struggling mental health care system in Texas and the Houston area. I know I would not want my child or family member deceived in such a manner. Your help in protecting those who already struggle to help themselves would be greatly appreciated.

Signed,

(Author's name withheld by request)

Announcements

Our 2008 annual 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 various Health Licensing Boards of North Carolina. The preliminary program and a registration form may be downloaded from our website: http://www.cacenter.org.

PowerPoint Presentations from the multi-disciplinary Continuing Competence Workshop that we held on May 12 and 13, 2008, are now available on our website at: http://www.cacenter.org/PowerPoint2008/index.html

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