News & Views

Citizen Advocacy Center

Second Quarter, 2009 | A Health Care Public Policy Forum | Volume 21 Number 2

Announcements

CAC is now a membership organization *and we invite your board to join. For information about the benefits that are available to our members, and for a membership enrollment form, please see pages 25 and 26 of this issue or go to www.cacenter.org/files/membership.pdf.*

Our 2009 Annual Meeting *will be held on Wednesday, Thursday, and Friday, October 28, 29, and 30, 2009, at the Royal Plaza Hotel in Lake Buena Vista, Orlando, Florida. For more information please see www.cacenter.org/cac/meetings.*

CONTINUING COMPETENCE

Colorado Adopts Continuing Competence Law for Mental Health Professions

Colorado has enacted a law authorizing the boards that regulate several mental health professions to establish continuing competence requirements as a condition of licensure renewal. The legislative summary for House Bill 09-1086 explains its contents as follows:

On or after January 1, 2011, requires licensed clinical social workers, licensed social workers, licensed marriage and family therapists, licensed professional counselors, licensed addiction counselors, and level II or level III certified addiction counselors to maintain continuing professional competency in order to obtain renewal or reinstatement of a license or certificate to practice their respective professions in Colorado. Authorizes the governing body that regulates the respective professions to develop, by rule, a continuing

~ Table of Contents ~

CONTINUING COMPETENCE
Colorado Adopts Continuing Competence Law For Mental Health Professions 1
Federation of State Boards of Physical Therapy Continues Newsletter Series on Continuing Competence 4
Oregon Medical Board Approves CME Requirements 6

SPOTLIGHT
Montana Adopts Uniform Rules for Public Disclosure of Board Discipline 7

SCOPE OF PRACTICE
Physical Therapy Board Association Advances "New View on Scope of Practice Debates" 7
Idaho Licenses Certified Professional Midwives 8
Some States Add Tiers to Social Worker License 9
Ontarians Favor Larger Role for Pharmacists 9

QUALITY OF CARE
Economic Value of Nurses Documented 10
Nurses as Patient Advocates 10
Nevada Considers Intensified Inspection of Outpatient Clinics 11

IN DEPTH
Colorado Board of Nursing Probation Manual 11

continued on page 2…

professional competency program for the applicable profession that assesses the licensee's or certificate holder's ongoing ability to learn, integrate, and apply the knowledge, skill, and judgment necessary to practice the profession according to generally accepted industry standards and professional ethical standards in the role and setting in which the licensee or certificate holder is engaged in the practice of the profession.

The pertinent language in the legislation reads for each affected profession:

> (1) (a) In accordance with section …, the board issues a license to practice as a (name of the profession) based on whether the applicant satisfies minimum education and experience requirements that demonstrate professional competency to practice as a licensed (professional). After a license is issued to an applicant, the licensed (professional) shall maintain continuing professional competency to practice as a (professional).
>
> (b) The board shall adopt rules establishing a continuing professional competency program that includes, at a minimum, the following elements:
>
> (I) a self-assessment of the knowledge and skills of a licensed (professional) seeking to renew or reinstate a license;
>
> (II) development, execution, and documentation of a learning plan based on the assessment; and
>
> (III) periodic demonstration of knowledge and skills through documentation of activities necessary to ensure at least minimal ability to safely practice the profession. Nothing in this paragraph (III) shall require a (licensee)

…continued from page 1

ETHICS
Doctors Ask Patients to Agree Not to Post Comments Online 14

AUDIT
Georgia Secretary of State Handel Announces Support of Legislation Requiring Scheduled Review of Regulatory Boards 14
Washington State Auditors Explore Criteria for Selecting Boards for Review 15
Texas Medical Board Undergoes Sunset Review 16

DISCIPLINE
Convicted Murderer's License Reinstated 16
Nurse's Record Concealed behind Colleagues' Fears and Privacy Laws 17
Board Chooses Monitoring Rather Than Discipline for Infection Control 17
Hospital Report Causes Doctor to Lose License 17
Mandatory Reporting Law Goes Unenforced 18

ROLE OF THE PUBLIC MEMBER
Clinical Trial IRBs Susceptible to Manipulation, Says GAO 18

COMPLEMENTARY AND ALTERNATIVE MEDICINE
Air Force to Train Doctors in Acupuncture 19
Study Shows Growing Use of Complementary and Alternative Medicine 19

CONSUMER INFORMATION
California Doctors Oppose Waiting Room Sign Proposal 21

MEMBERSHIP
CAC is Now a Membership Organization 25
CAC Membership Enrollment Form 26

NOTICE

CAC derives a significant portion of its operating funds from the sale of this newsletter. By purchasing an online subscription to **CAC *News & Views***, you are entitled to download one copy of each newsletter. Unauthorized reproduction of our newsletters (whether through multiple downloads or through the use of a copy machine) undermines our ability to fulfill our mission.

Once a representative of an organization has subscribed to **CAC *News & Views*** online for $195.00 for one year, additional members of that same organization may subscribe for $50.00 each.

CAC membership includes a ***free*** subscription to our newsletter. A membership application may be found at the end of this newsletter.

to retake any examination required pursuant to section 12-43-404 in connection with initial licensure.

(c) The Board shall establish that a (licensee) is deemed to satisfy the continuing competency requirements of this section if the (licensee) meets the continued professional competence requirements of one of the following entities:

- A state department, including continued professional competence requirements imposed through a contractual arrangement with a provider,
- An accrediting body recognized by the board, or
- An entity approved by the board.

(d) (I) After the program is established, licensed (professionals) shall satisfy the requirements of the program in order to renew or reinstate a license to practice as a licensed (professional) in Colorado.

(II) The requirements of this section apply to individual (licensees)… and nothing in this section shall be construed to require a person who employs or contracts with a (licensee) to comply with the requirements of this section.

(2) (a) Records of assessments or other documentation developed or submitted in connection with the continuing professional competency program are confidential and not subject to inspection by the public or discovery in connection with a civil action against a licensed (professional). The records or documents shall be used only by the board for purposes of determining whether a licensed (professional) is maintaining continuing professional competency to engage in the profession.

(b) Subject to the requirements of paragraph (a) of this subsection (2), nothing in this section shall be construed to restrict the discovery of information or documents that are otherwise discoverable under the Colorado Rules of Civil Procedure in connection with a civil action against a (licensee).

Board of Directors

Honorary Chair Emeritus (deceased)
Benjamin Shimberg

Chair
Rebecca LeBuhn

President and CEO
David Swankin

Secretary/Treasurer
Ruth Horowitz

Vice Presidents
Len Finocchio Mark Speicher

Directors
Carol Cronin Julie Fellmeth
Gary Filerman Arthur Levin
Cheryl Matheis Mark Yessian
Barbara Safriet Polly Johnson

CAC *News & Views* is published quarterly by the

Citizen Advocacy Center

1400 Sixteenth Street NW
Suite #101
Washington, DC 20036
Phone: (202) 462-1174 Fax: (202) 354-5372
Email: cac@cacenter.org

Editor-in-Chief: Rebecca LeBuhn
Contributing Editor: David Swankin
Newsletter Layout and Subscription Manager: Steven Papier

© 2009, Citizen Advocacy Center

> (3) As used in this section, continuing professional competency means the ongoing ability of a licensee to learn, integrate, and apply the knowledge, skill, and judgment to practice as a licensed (professional) according to generally accepted industry standards and professional ethical standards in a designated role and setting.

Editorial Note: CAC congratulates the Colorado legislature for initially drafting such a comprehensive and specific set of requirements calling for individual assessment, the development of a learning plan based on the assessment, and periodic demonstrations of competence as a condition of retaining a professional license. We encourage the responsible boards to write equally comprehensive and clear implementing rules.

We takes particular note that when the bill governing mental health workers was being considered in the Colorado House on March 20, 2009, the section requiring periodic demonstrations of current competence was amended to require each mental health licensing board to "establish" that a licensee "is deemed to satisfy the continuing competence requirements of this section if the(licensee)meets the continued professional competence requirements of one of the following entities: (I) a state department ,including continued professional competence requirements imposed through a contractual arrangement with a provider; (II) an accrediting body recognized by the board, or; (III) an entity approved by the board.

Therefore, it will be up to each affected licensing board, during rulemaking, to determine which accrediting bodies will be "recognized" and which entities will be "approved" by the board. The criteria for making such determinations will be critical if the original intent of the legislation is to be honored. CAC will be watching carefully.

Federation of State Boards of Physical Therapy Continues Newsletter Series on Continuing Competence

The Federation of State Boards of Physical Therapy printed another article about continuing competence in the Fall 2008 issue of ***federation forum*** (Volume 23, Number 2). In "Moving Toward Continuing Competence," Leslie Adrian explores multiple pathways to maintaining and demonstrating current competence. Excerpts from her article appear below:

> **Initial demonstration of competence -** Every newly licensed physical therapist has demonstrated competence in the practice of physical therapy by successfully passing the NPT. Each new professional accepts a great responsibility when he or she receives that license. The significance is not lost on most of the candidates who have invested a lot of money and time into this accomplishment. Competence is a quality this person has been deemed to possess. It implies a certain level of knowledge or qualification and adequacy of a required skill within a profession.
>
> **Beyond initial demonstration of competence** - In 5, 10, or 20 years does this same therapist still feel the incentive to remain competent? Continuing competence is a process of maintaining that same knowledge, qualification, and skill. It implies action on the part of the licensee.

The difference between competence and continuing competence is subtle, but distinct. Although it is an inherent responsibility of all licensees to remain competent, it is unclear what can be done to ensure that licensees will invest the required energy to maintaining competence as they did to achieving it in the first place. Competence is the minimum standard; some choose to significantly exceed this standard while others in the field become complacent and disengaged, barely meeting the minimum standard if they do so at all.

Continuing education - Most people would argue that there are a number of ways to maintain competence in the field of physical therapy… Many states just have one option – continuing education. Thirty-seven jurisdictions require continuing education units, ranging from 10-40 hours as a requirement for physical therapist licensure renewal. Thirty-three jurisdictions have CEUs ranging from 6-40 hours as a requirement for physical therapist assistant licensure renewal. Many more jurisdictions are looking at, or are in the process of adding, a CEU requirement…

The goal is a competent provider – Mandated clinical education attempts to ensure competent providers. But the nagging question remains, how do we know it works? The answer is we don't… The jurisdiction must be mindful that the goal is to have a competent provider, not a provider who has attended a lot of courses or logged a lot of hours. The jurisdiction is then caught trying to balance protection of the public from incompetent providers and allowing enough flexibility for a licensee to learn in a documented, substantiated way that best suits hi or her needs.

Moving to continuing competence
The time has come to recognize that paired with self-reflection and assessment by the licensee, a host of different activities can be linked together to create a comprehensive plan for continuing competence. Continuing professional education has a place in a continuing competence plan. It is an option, it's just not, and should not be, the only option.

Beginning in 2009, we will see concerted efforts jurisdictions to replace continuing education with continuing competence. Recently, California and North Carolina have gone through the process of mandating continuing competency requirements rather than CEUs… Each jurisdiction will be pre-approving activities for their quality and relevance to physical therapy. The boards will require documentation and evidence of completion, record keeping by the licensee, and will require a component of assessment from many of the activities…

A partnership between the jurisdiction and the licensee – Culturally, continuing competence needs to be seen as a partnership between the jurisdiction and the licensee. Jurisdictions want licensees to embrace the spirit of lifelong learning to be not only in their best interest, but in the best interest of their clients… There must

be a shift towards judging activities for their value and quality, rather than the number of hours for completion…

Continuing competence – Practitioner demonstration of ongoing continuing competence is coming. Consumers and consumer advocacy groups are demanding it. Some state legislatures as well as some of our jurisdiction members are requiring it or considering it. Professional associations are recommending and/or endorsing it. And a reasonable and efficient method for practitioners to demonstrate continued competence is the right thing to do.

The Federation's Comprehensive Continuing Competence Program is evolving rapidly. The Program will offer incredible flexibility for boards to choose and ensure enforcement of continuing competence standards that meet their specific needs. An efficient 100% audit of all licensees will be available…

To read the entire article, visit the* Federation Forum Vol. 23 Number 2 *at www.fsbpt.org/download/Forum_Vol23_No2.pdf.

Oregon Medical Board Approves CME Requirements

In its Winter 2009 ***Report***, the Oregon Medical Board (www.oregon.gov/OMB) reports that it adopted continuing medical education requirements at its January 2009 meeting. According to the article,

The new rule (OAR 847-008-0070) states that for a licensee to renew his or her license, he or she must demonstrate continued competency through either:

Ongoing participation in re-certification by an American Board of Medical Specialties (ABMS) board, the American Osteopathic Association's Bureau of Osteopathic Specialists (A)A-BOS), the National Commission on Certification of Physician Assistants (NCCPA), or the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM); or

30 hours of Category 1 continuing medical education (CME) per year relevant to the licensee's current medical practice.

After much discussion, the Board agreed that these standards follow the requirements of all certifying board standards, and therefore would not impose a hardship on licensees.

Editorial Note: For a "continuing competence" policy enacted in 2009 when more and more stakeholders are acknowledging that continuing education is not an adequate surrogate for continuing competence, this one is surprisingly old school. CAC believes that meeting the re-certification requirements of an ABMS board comes as close as anything currently available to an actual demonstration of current competence. However, this admirable approach is totally undercut by the offer of 30 hours of CME as an alternative to maintenance of certification. By doing so, the OMB's policy applies

radically different standards to different categories of licensees, while leaving the impression with the public that all practitioners who hold a current license have been equally challenged to demonstrate current competence. "Hardship" to the licensees is scarcely the consideration that should govern a current competence policy.

SPOTLIGHT

Montana Adopts Uniform Rules for Public Disclosure of Board Discipline

This quarter, **CAC** ***News & Views*** applauds the state of Montana for adopting a uniform framework that applies to all boards and programs in the Department of Labor and Industry for purposes of posting disciplinary orders on their licensee lookup data bases. Hearings were held in February to approve a new rule to implement legislation passed in 2007. The proposed rule provides that:

> (1) Unless the exceptions in (2) and (3) are applicable, any final order imposing a sanction against a professional or occupational license holder that is based on competence to practice issues or based on an allegation that generally or specifically is a violation of law or regulation, is a "disciplinary action" that must be published and noted on the licensee lookup.
>
> (2) If a final order is based only upon a failure to file or complete in a timely manner a minor administrative requirement that is in rule or law, the order affecting the licensee is not a "disciplinary action" for the purposes of publication and notice on the licensee lookup.
>
> (3) A final order of license denial based solely upon an applicant's failure to meet minimum licensure qualifications and not based on competence to practice issues or involving the applicant's past disciplinary or legal actions is not a "disciplinary action" for the purpose of publication and notice on the licensee lookup.

SCOPE OF PRACTICE

Physical Therapy Board Association Advances "New View on Scope of Practice Debates"

The following article is excerpted from the Winter issue of the Federation of State Boards of Physical Therapy's* Forum *newsletter. (See* www.fsbpt.org/download/Forum_Winter09_ScopeOfPractice.pdf*).

> The specific title may vary, but each of the 53 member jurisdictions of the Federation of State Boards of Physical Therapy has a physical therapy practice act which has been passed into law by the state legislature. The respective State Board then writes rules and regulations based on that statutory authority to give practical meaning to the law. The unique nature of each state's political landscape is demonstrated in the state-to-state variance of the practice acts for the same profession.
>
> …These laws are not static, however; they are dynamic and evolving legisla(tively). Sometimes the changes being debated are contentious, other times they are non-controversial. Traditionally,

battles over scope of practice have been hard fought endeavors.

From the outside, battles between professional groups for inclusions or exclusions to scope of practice legislation are perceived as turf wars. Obviously, professions want to see their scope of practice expanded to the maximum, while limiting the scope of practice of other potentially competing professionals, in order to strengthen a competitive advantage in the health care market. There have been many instances in the states where in one year a given profession is fighting to expand its practice act in the name of the good of the public, improved access to health care providers, increased choice, decreased costs, improved public health; only to turn round the following year and fight against another profession trying to do the same thing.

What often gets lost, however, is that the legislature should be acting based on what is in the best interest for public protection and safety. Unfortunately, many of the differences between state practice acts are not based on any specific public protection measures or research, but by who had the deepest pockets during the legislative session. In order for the debate on the scope of practice for a healthcare profession and resulting legislation to be meaningful, a major culture shift must take place. Legislators must take an objective view of proposed scope of practice changes with regard to public safety and minimize the influence of professional special interest group lobbyists.

FSBPT collaborated with five other healthcare regulatory organizations to publish *Changes in Healthcare Professions Scope of Practice: Legislative Considerations*. This document has been developed to assist legislators and regulatory bodies with making decisions about changes to healthcare professions' scopes of practice. These organizations present the argument that if a profession can provide support evidence in four areas: 1) an established history of the practice scope within the profession. 2) education and training, 3) supporting evidence, and 4) appropriate regulatory environment; the proposed changes in scope of practice are likely to be in the public's best interest.

The idea or a new way of looking at health profession scope of practice legislation is evolving. Increasingly, legislatures are recognizing that there needs to be an unbiased and impartial way to evaluate a request by a healthcare profession to expand the scope of practice…

Idaho Licenses Certified Professional Midwives

On April 1, 2009, Idaho's Governor C. L. "Butch" Otter signed a law licensing certified professional midwives. Proponents of the legislation remarked at the unprecedented level of cooperation between professional midwives, physician groups, and advocates to reach a consensus. The law provides for independent practice,

collaboration, and the right of parents to choose where they wish to give birth.

Some States Add Tiers to Social Worker License

Tennessee and Missouri recently passed legislation modifying their social work licensure laws, according to the Association of Social Work Boards' October 2008 Vol. 18 Number 5 A***ssociation News.*** (See www.aswb.org/pdfs/ASWBNews1008.pdf):

> Tennessee has modified its social work statute to move to mandatory licensure for multiple practice levels. Effective July 1, 2008, the Board of Social Work Certification and Licensure was renamed the Board of Social Work Licensure. In addition, the law creates four license categories, adding bachelor and advanced practice to their license categories. The new law establishes licenses that include Licensed Baccalaureate Social Workers, Licensed Master's Social Worker, Licensed Advanced Practice Social Worker (non-clinical) and Licensed Clinical Social Worker.
>
> Missouri also passed a new law that included language adding three new tiers of licensure and renaming one. Their law now includes Licensed Advanced Macro Social Worker, Licensed Master Social Worker, License Baccalaureate Social Worker and Licensed Baccalaureate Social Worker-Independent Practice. They also changed the LCSW scope of practice by deleting community organization, planning and evaluation and adding social work theory, knowledge and values. The new statutes and definitions are available at the board's Web site: pr.mo.gov/socialworkers.asp.

Ontarians Favor Larger Role for Pharmacists

Marking the beginning of Ontario's Pharmacist Awareness Week, the Ontario Pharmacists' Association (OPA) released the results of an Ipsos Reid survey which found that seventy-one percent of Ontarians believe that pharmacists could do more to help them manage their health. Many respondents said they would rely on appropriately trained pharmacists for a wide range of services.

Specifically, eighty-six percent of Ontarians said they would rely on their pharmacist to provide appropriate medication or advice for minor ailments; eighty four percent would rely on a pharmacist to adjust medication format, such as from a pill to a liquid; and sixty-seven percent would rely on a pharmacist to authorize prescription extensions where there are no existing refills. Two-thirds reported they already rely on their pharmacist for support with minor health issues.

To practice in Ontario, pharmacists have at least five years of university education, including course work in physiology, microbiology, pathophysiology, clinical biochemistry, pharmacology, toxicology and pharmaceutical care. Many pharmacists undertake additional post-graduate training to become certified as diabetes or asthma educators, and some may specialize in areas such as geriatrics and menopause.

Pharmacists already provide many health services, such as screening for cholesterol and diabetes management, hosting flu shot clinics, and educating consumers. Pharmacists provide information about how to take prescribed medications, recommend treatments for minor illnesses and make referrals to specialists.

By making better use of their unique expertise, pharmacists can help improve

patient care, take pressure off family physicians, emergency rooms and walk-in clinics, reduce wait times and hospital stays, and increase the efficiency and effectiveness of Ontario's health care system. The Ontario government is currently considering an expanded role for pharmacists, in part to increase efficiency and effectiveness in health care delivery. More extensive use of pharmacists could, for example, relieve pressure and reduce wait times in emergency rooms and walk-in clinics.

Ontario's Health Professions Regulatory Advisory Council recommends in a report entitled "Critical Links: Transforming and Supporting Patient Care," that pharmacists be given the authority to authorized to adapt, modify and extend an existing prescription and order laboratory tests as part of medication monitoring and management. The council also recommends the creation of an Interprofessional group which would determine which minor ailments (such as dermatitis, cold sores, eye infections, yeast infections, and athlete's foot) pharmacists could treat under an agreed formulary and collaborative practice agreements.

An expanded scope of practice for pharmacists would be preceded by the development of standards and guidelines. These could include requirements for continuing education and additional certification to qualify for the expanded scope.

QUALITY OF CARE

Economic Value of Nurses Documented

In late December, the American Nurses Association (ANA), on behalf of the larger nursing community, announced the release of a first of its kind study quantifying the economic value of nursing. The research, first proposed in 2003 and published in the January 2009 issue of the journal Medical Care, is the result of years of analysis of data on the correlation between patient outcomes and nurse staffing levels. Estimates from this study suggest that adding 133,000 RNs to the acute care hospital workforce would save 5,900 lives per year. The productivity value of total deaths averted is equivalent to more than $1.3 billion per year, or about $9,900 per additional RN per year. The additional nurse staffing would decrease hospital days by 3.6 million. More rapid recovery translates into increased national productivity, conservatively estimated at $231 million per year. Medical savings is estimated at $6.1 billion, or $46,000 per additional RN per year. Combining medical savings with increased productivity, the partial estimates of economic value averages $57,700 for each of the additional 133,000 RNs.

This project was the culmination of years of research and collaboration between the ANA, the American Association of Critical Care Nurses (AACN), the Oncology Nursing Society, the American Organization of Nurse Executives, and 85 other nursing organizations who contributed to the project. To read the complete article at no charge, visit www.lww-medicalcare.com.

Nurses as Patient Advocates

An analysis of the fifth annual *National Healthcare Quality Report* and *National Healthcare Disparities Report* sponsored by the Agency for Healthcare Research and Quality (AHRQ) and conducted by researchers Karen Ho, M.S., Jeffrey Brady, M.D., and AHRQ Director Carolyn M. Clancy concluded that the rate of quality improvement has slowed, but that nurses are in a position to advocate in behalf of patients for higher quality, more equitable care.

The reports show an improvement in quality of care of only 1.5% per year between 2000 and 2005. The 2007 reports showed gains in the proportion of heart attack patients who received recommended tests, medication, or counseling and a reduction in disparities in childhood vaccines, but patient safety showed an annual average improvement of only one percent.

There was a notable lack of improvement in communication between hospital patients and their physicians and nurses about new medications and discharge information. The researchers were also troubled by the lack of diversity in the nursing workforce – nearly eighty-two percent of nurses in 2004 were white, even though the proportion of racial / ethnic minority nurses had increase threefold between 1980 and 2004.

***Additional details can be found in* Improving Quality and Reducing Disparities: The Role of Nurses *in the July – September* Journal of Nursing Care Quality, pp. 185-88.**

Nevada Considers Intensified Inspection of Outpatient Clinics

In the aftermath of a hepatitis outbreak in Las Vegas potentially affecting 50,000 patients a two outpatient clinics, the Nevada legislature is considering improved inspections of such facilities, particularly for infection control. Several bills under consideration suggest a variety of measures, including stronger whistle-blower protection for nurses who report unsafe conditions, expanded requirements for reporting and investigating major patient problems, and annual inspections of outpatient clinics and physicians' offices where general anesthesia, deep sedation and conscious sedation are used. These doctor's offices would be required to obtain a state permit and earn national accreditation.

In testimony before a joint committee hearing, the Nevada State Medical Association asked the legislature to go slow, arguing that the proposals aren't practical. The association's executive director recommended exempting doctor's offices that do conscious sedation and concentrating on procedures that expose patients to the highest risk. The association also argued that annual fees of $2,000.00 - $3,000.00 and the cost of obtaining accreditation would be burdensome.

IN DEPTH

Colorado Board of Nursing Probation Manual

Editorial Note: This quarter's IN DEPTH Feature describes the Colorado State Board of Nursing's Probation Manual for Licensees and Practice Monitors. This detailed and comprehensive document provides step-by-step guidance for licensees who have been put on probation and for the practice monitors who oversee their probation. Visit www.dora.state.co.us/nursing/complaints/bon_probation_manual.pdf ***to download a complete copy of the Manual.***

The introduction to the ***Probation Manual*** enumerates the standards against which the practice of registered nurses and licensed practical/vocational nurses are evaluated. It then explains that the goal of the manual is to create objective measures to evaluate a licensee's practice. The ***Manual*** makes it clear that "The Board expects that the probationary experience will empower both the Licensee and the Practice Monitor to

uphold, promote, and model the Standards, conduct and ethics of the nursing profession in their daily nursing practice."

The manual follows the phases of the probation process itself:

Phase 1 – Orientation to Probation
Phase 2 – Evaluation of a Licensee's Practice
Phase 3 – Practice Monitor Plan
Phase 4 – Monitoring Practice
Phase 5 – Termination of Probation

The ***Manual*** concludes with an appendix containing all the procedures and forms needed to satisfy each phase of probation.

The orientation section of the ***Manual*** sets forth the responsibilities of the licensee and the practice monitor and directs them to the various reporting forms. Significantly, the ***Manual*** specifies that:

> It is the Licensee's responsibility to ensure that probationary reports and documents required by the Stipulation are submitted to the Board by the Practice Monitor on time. If a report is going to be late, the Licensee must contact the Board Enforcement Specialist to provide an explanation and the request an extension.

The practice monitor and the licensee share responsibility for the evaluation phase. The practice monitor's evaluation includes:

- An interview with the licensee,
- Direct observation of the licensee's practice,
- An audit of the licensee's documentation,
- A review of patient case studies and subsequent nursing care plans assigned to the licensee by the practice monitor,
- Attendance at cross shift report,
- Information discussions with patients, family, other members of the health care team and nursing colleagues about the licensee's nursing practice, and
- A review of the licensee's self-evaluation.

The licensee's instructions for self-evaluation begin with a pep talk encouraging him or her to view the situation in a positive light:

> Many licensees experience the complaint to the Board as a crisis and the subsequent disciplinary process as a continuation of that crisis. This process is intended to provide positive change and can result in a higher level of functioning for the individual, if the individual is willing to do the internal and external shifts in practice as a result of this action.

The board "encourages" licensee's who are on probation to regularly undertake "an honest inventory" of their practice, including:

- Objectively reflect on your nursing practice,
- Compare your practice to the Standards and Nurses' Code of Ethics,
- Write down the results of your self-evaluation,
- Share your self-evaluation with your practice monitor, and
- Use the results of the self-evaluation to contribute to the Focused Action Plan in the Practice Monitor Plan.

Phase 3 introduces the Practice Monitor Plan (PMP) which is a collaborative effort between the practice monitor and the licensee. According to the ***Manual***, the

PMP "should be a fluid document that is modified, as appropriate, during the probation…"

> Based on the practice breakdown(s) identified in the Stipulation, the licensee's self-evaluation, the practice monitor's evaluation of the licensee's practice, the likely cause(s) of the licensee's practice breakdown can be identified. The Focused Action sections of the PMP outline the actions to be taken by the licensee and the practice monitor to remediate the practice breakdown and to monitor practice.

There are seven substantive components to the PMP:

- Practice breakdown identification,
- Outcome of the probation,
- Probation standards,
- Required actions to remediate practice breakdown,
- Focused actions to remediate practice breakdown,
- Required actions to monitor practice, and
- Focused actions to monitor practice.

The ***Manual*** lists numerous actions taken by licensees and practice monitors in the past that have been successful in achieving remediation of practice breakdowns. There is no obligation to engage in any of these actions; they may be modified as appropriate, or the licensee and practice monitor may design actions of their own.

The suggested actions based on past success include:

- Read professional literature,
- Collaborate with a mentor to develop skills,
- Develop and present an in-service about practice breakdown or current standards of care,
- Develop a self-care plan based on self-evaluation,
- Document pain assessments prior to and after administering narcotics.

Tested actions associated with practice monitoring include:

- Observe licensee providing direct patient care,
- Observe licensee's interactions with health care team,
- Assign licensee professional literature articles pertaining to practice breakdown,
- Assign licensee to interview other nurses about how they avoid practice breakdown,
- Assign licensee to observe expert nurse providing patient care.

Phase 4 is actual monitoring of practice. The practice monitor is required to submit a report quarterly. The ***Manual*** recommends that the monitor discuss the report with the licensee at their weekly meetings.

When the practice monitor and licensee agree that it is appropriate, the licensee may submit a request for termination of probation. The request must include the licensee's assessment of how his or her practice has changed and what strategies he or she will use in the future to avoid practice breakdown. The practice monitor's recommendation for termination of probation must include his or her evaluation of the licensee's practice, specific examples of improvement, and an assessment of the licensee's ability to practice safety without further monitoring.

Editorial Note: This Probation Manual provides a detailed structure for a successful probation period. The most important thing it accomplishes may be the specification of duties for the probation monitor. The monitor's responsibilities are significant and time-consuming so no one

should undertake this assignment without a full understanding of what is expected by the nursing board and a commitment to meet those expectations.

ETHICS

Doctors Ask Patients to Agree Not to Post Comments Online

With the introduction of online sites for patients' reviews of doctors (two are managed by restaurant review sites Zagat's and Angie's List; another is called www.RateMDs.com), some doctors are asking their patients to sign waivers agreeing not to post comments or reviews of the doctor online. Some medical ethicists question this trend, branding it unprofessional and even adversarial toward patients.

In defense of the doctors, some argue that patient's reviews may have little to do with a doctor's medical knowledge and skills and could, especially in the case of anonymous reviews, be cheap shots leveled by disgruntled patients or even co-workers. Dr. Jeffrey Segal, founder of a firm called Medical Justice which distributes a standardized waiver agreement and notifies doctors of negative postings so they can try to get them removed, recommends that doctors refuse to treat patients who won't sign a waiver.

RateMDs.com refuses to remove negative comments and is threatening to post a "wall of shame" identifying doctors who attempt to censor their patients' reviews. The American Medical Association has yet to take a position on the waivers

Editorial Note: Is this an area where it is appropriate for medical boards to intervene? At a minimum, they could issue a guideline expressing an opinion about the propriety of these waivers.

AUDIT

Georgia Secretary of State Handel Announces Support of Legislation Requiring Scheduled Review of Regulatory Boards

Georgia Secretary of State Karen Handel today announced on February 16, 2009, the introduction of legislation that would require the Georgia Occupational Regulatory Review Council (GORRC) to perform a periodic review of each board currently regulated by Title 43 of the Georgia Code. The legislation, sponsored by Sen. David Shafer (R-Duluth) and Rep. Roger Williams (R-Dalton), will require GORRC to evaluate and determine if the particular regulation is still necessary and if the regulation provides adequate consumer protection. The review would also assess the overall cost effectiveness and economic impact of the regulation.

The Secretary of State's Professional Licensing Boards Division provides administrative support services to 36 professional licensing boards that issue 197 types of licenses to more than 400,000 Georgians in various professions. In Spring 2008 Handel ordered a comprehensive external audit of the Division's operations, which found numerous inefficiencies. Handel has since streamlined the Division by reorganizing and consolidating employee functions, cutting positions and implementing proven business principles.

GORRC is comprised of the following or their designee: the Comptroller General; the Secretary of State; the commissioner of Human Resources; the director of Office of Planning and Budget; the commissioner of

Natural Resources; the State Revenue Commissioner; the Commissioner of Agriculture; the administrator of the Fair Business Practices Act of 1975; the chairperson of the legislative committee of reference; and the chairperson of that standing committee of the General Assembly appointed by the presiding officer.

More information on the legislation, HB 424 can be found on the Georgia General Assembly website: www.legis.state.ga.us/legis/2009_10/sum/hb424.htm.

Washington State Auditors Explore Criteria for Selecting Boards for Review

Washington State's Joint Legislative Audit and Review Committee (JLARC) issued a "pre-audit" report (#08-13) on December 3, 2008, proposing four possible approaches the legislature could use to more systematically track boards and commissions. JLARC writes that the legislature could give priority attention to (a) boards with little activity, (b) boards with a high impact on state resources, (c) boards that license or adjudicate, and/or (d) boards that operate within a particular topic area.

According to the report, if the legislature were to give priority to reviewing boards and commissions with little activity (e.g., fewer than three meetings a year and operation costs of less that $10,000 per biennium), its focus could be on the potential impacts of termination or consolidation. Examples of boards that might fall into that category are the Acupuncture Ad Hoc Consulting Group, Breast & Cervical Health Program Advisory Committee, Midwifery Advisory Committee, and the Orthotics & Prosthetics Advisory Committee.

If the legislature were to choose to focus on boards and commissions with a high impact on state resources (e.g., $250,000 or more per biennium), a sunset review might focus on efficiency and effectiveness. Boards falling into this category include the Chiropractic Quality Assurance Committee, the Dental Hygiene Examining Committee, the Dental Quality Assurance Commission, the Medical Quality Assurance Committee, the Nursing Care Quality Assurance Commission, and the Boards of Pharmacy and Physical Therapy.

If the legislature were to select the third option – to review boards and commissions that adjudicate or license, its focus would be "sunset-like" and the entities could be recommended for modification, termination, or consolidation. Boards in this category include the boards and commissions listed in category two plus the boards that regulate denturists, psychologists, funeral directors and embalmers, hearing and speech therapists, massage therapists, occupational therapists, osteopathic physicians and surgeons, podiatrists, and veterinarians.

Finally, if the legislature were to give priority to boards and commissions by topic area, its review would focus on overlapping responsibilities and entities could be recommended for modification, termination or consolidation.

As background, the report summarizes the review approaches taken in other states, Arizona, Colorado, Florida, Maine, Texas, and Virginia.

The full JLARC report can be found at: www1.leg.wa.gov/JLARC/Audit+and+Study+Reports/2008/boards+and+commissions.htm.

Texas Medical Board Undergoes Sunset Review

The Texas Sunset Advisory Commission completed a performance study of the Texas Medical Board in November 2008. This was not a "full Sunset review," but rather a legislature-requested special purpose review to assess the timeliness of license issuance and the fair and effective enforcement of the Medical Practice Act. The report is "informational" and contains no recommendations.

Summarizing its findings, the advisory commission writes:

> In conducting this performance study, Sunset staff found that the Board has succeeded in improving its performance regarding the time it takes to issue physician licenses, and, but the end of fiscal year 2008, met both its performance target and statutory requirement for this measure. Within the agency's enforcement division, increasing numbers of complaints, quality of care cases, and active cases could contribute to higher enforcement costs, heavier staff workload, and ultimately more time to resolve complaints. Strained agency resources could limit its ability to meet future performance targets and maintain its current level of service to its regulated community and the public.

During fiscal year 2008, the board received 6,514 complaints. Investigations were opened in 2,725 cases. The board resolved 2,535 complaints and imposed sanctions in 352 cases.

Of these complaints, a majority (sixty-eight percent) were filed by patients or friends and family of patients. The percentage of complaints opened for investigation increased from thirty-three percent in 2002 to forty-two percent in 2008.

An impressive seventy-three percent of complaints involved quality of care issues, but only nine percent of these resulted in disciplinary action in 2008. The categories of complaints that resulted in the highest percentage of disciplinary action were substance abuse (seventy-nine percent); mental or physical impairment (sixty-five percent); administrative issues (fifty-three percent) and criminal behavior (forty-three percent).

Additional information can be found at: www.sunset.state.tx.us/

DISCIPLINE

Convicted Murderer's License Reinstated

Anesthesiologist Visuvalingam Vilvarajah's license to practice was reinstated by the Tennessee medical board seven years after he was convicted of murdering his wife and mother-in-law. His license was reinstated with restrictions in 1993. By 2001, all the restrictions were removed.

In February 2009, Vilvarajah and his partner were arrested in Kentucky on charges of engaging in organized crime involving prescriptions of large quantities of drugs not intended for the patients' personal use.

Editorial Note: A visit to the Tennessee medical board's Website to find out the

status of Vilvarajah's license as of April 2009 produced the following information: "no records found."

Nurse's Record Concealed behind Colleagues' Fears and Privacy Laws

California nurse, Gwen Hughes managed to evade detection for over-drugging nursing home residents despite being fired from two institutions, according to story by Stacey Shepard in the February 20, 2009, ***Bakersfield Californian*** (www.bakersfield.com). Shepard interviewed a former employer, but privacy laws prevented him from divulging anything about former employees other than the dates of the individual's employment and whether they are eligible for re-hire. A spokesperson for the Department of Health said the law wouldn't allow her to tell Shepard whether Hughes had been reported to the board of nursing. The board of nursing said they would have to check to see if there were complaints about Hughes in her file.

A former co-worker told Shepard that Hughes was a very intimidating personality who threatened nurses with being fired or reported to the board of nursing if they refused to write a medication order for her. Hughes was able to avoid discipline in part because there was not paper trail or over-prescribing with her name on it. Now that Hughes has been arrested and faces charges in the deaths of three nursing home residents, the Board of Registered Nursing intends to suspend her license.

Board Chooses Monitoring Rather Than Discipline for Infection Control

New York's Office of Professional Medical Conduct and the Nassau County District Attorney are monitoring infection control practices at Dr. Harvey Finkelstein's pain management clinic. A year ago, 10,000 of Finkelstein's patients were warned to get tested for blood borne diseases after the doctor was accused of re-using syringes and infecting a patient with hepatitis C.

Since then, Finkelstein has been the target of numerous malpractice suits and resigned positions at area hospitals. He continues to see patients at his clinic where investigators are satisfied his infection control procedures are adequate.

Editorial Note: The executive director of the Oklahoma Medical Board espoused the same philosophy to Vallery Brown, staff writer at the **Oklahoman** ***newspaper (November 30, 2008). He told her that "license revocation is a last resort. If the board members feel that if there is a remedy to salvage a doctor's career, they will look for ways to do that… We have to know enough in advance so we can get them (medical professionals) help. Once they've harmed someone, it's too late."***

Hospital Report Causes Doctor to Lose License

In an unusual turnaround, a California OB/GYN lost his license as a result of complaints by a hospital he had earlier successfully sued for nearly two million dollars in damages. The suit filed by Dr. John Brannigan against Memorial Hospital in Los Banos alleged that the hospital had retaliated against him for reporting unsafe conditions in the labor and delivery areas of the hospital.

A few months later, the hospital filed a complaint with the Medical Board of California citing several instances of "gross negligence and incompetence." The allegations reported by Carol Reiter in the

January 13, 2009, issue of the ***Merced Sun-Star*** included cutting the wrong body part in two separate tubal ligation surgeries, puncturing two other patient's uteruses, and patient abandonment in 2004 when the doctor left his practice. Brannigan failed to appear at the medical board hearing where his license was revoked.

Editorial Note: This case is another example of the importance of reports to licensing boards by health care institutions and co-workers.

Mandatory Reporting Law Goes Unenforced

A long investigative piece by Clark Kauffman in the ***Des Moines Register*** on January 25, 2009, explores the failure of health care workers to comply and state officials to enforce the state law that requires health care professionals to report cases of suspected dependent-adult abuse. Kauffman relates numerous instances of workers declining to report suspected or witnessed abuse, usually for fear of retaliation or out of a disinclination to be a "tattle-tale." He also reports cases in which nurses and others at long term care facilities were fired, allegedly because they reported instances of abuse to authorities. This is a violation of the whistle-blower protection in the mandatory reporting law.

Forty-four states have mandatory reporting laws, according to Kauffman, and lack of enforcement is chronic. A county attorney interviewed for the article speculated that prosecutors may hesitate to charge people with violating the mandatory reporting requirement because these are the very people needed to testify against the accused abuser.

ROLE OF THE PUBLIC MEMBER

Clinical Trial IRBs Susceptible to Manipulation, Says GAO

The Government Accountability Office has found that the Institutional Review Board System is vulnerable to unethical manipulation. In a report issued March 26, 2009, ***GAO Highlights*** writes, in part:

> The IRB system is vulnerable to unethical manipulation, which elevates the risk that experimental products are approved for human subject tests without full and appropriate review. GAO investigators created fictitious companies, used counterfeit documents, and invented a fictitious medical device to investigate three key aspects of the IRB system. These are the results:
>
> GAO created a … bogus IRB… A real medical research company contacted the bogus IRB to get approval to join ongoing human trials involving invasive surgery… Since the transaction involved privately funded human subjects research and did not involve any FDA-regulated drugs or devices, GAO's bogus IRB could have authorized this testing to begin without needing to register with any federal agency.
>
> GAO also registered its bogus IRB with HHS, and used this registration to apply for an HHS-approved assurance for GAO's fictitious medical device company… Even

though the entire process was done online or by fax – without any human interaction – HHS approved the assurance for GAO's fictitious device company. With an HHS-approved assurance, GAO's device company could have applied for federal funding for human subjects research.

GAO succeeded in getting approval from an actual IRB to test a fictitious medical device on human subjects. GAO's fictitious device had fake specifications and matched several examples of "significant risk" devices from FDA guidance. The IRB did not verify the information submitted by GAO, which included false information that FDA had already cleared GAO's device for marketing… (T)wo other IRBs that rejected GAO's protocol cited safety concerns with GAO's device…

GAO briefed HHS officials on the results of its investigation. The director of OHRP stated that, when reviewing assurance applications, HHS does not consider whether IRBs listed on the application are adequate – even though HHS is required to do so by law. In addition, HHS officials stated that the department does not review assurance applications to determine whether the information submitted by applicants is factual.

Editorial Note: This story appears in the section on ROLE OF THE PUBLIC MEMBER because IRBs that are federally approved are required to have public members and those public members should be pressing their IRB and the government agencies with which they interact to protect the integrity of the system. The credibility of all IRBs suffers if a few can compromise the system.

COMPLEMENTARY AND ALTERNATIVE MEDICINE

Air Force to Train Doctors in Acupuncture

The Air Force has announced that it will begin training doctors assigned to Iraq and Afghanistan in "battlefield acupuncture" for pain relief. According to Noah Shachtman, writing for the online version of ***Wired*** (blog.wired.com/defense/2008/12/air-force-turns.html):

> The military medical community has been using all sorts of alternative therapies -- yoga, meditation, even animal-petting -- to ease the strains of post-traumatic stress disorder for returning troops… "The (battlefield acupuncture) initiative marks the first high-level endorsement of acupuncture by the traditionally conservative military medical community, officials said…"
>
> Meanwhile, other Eastern-inspired techniques are slowly spreading throughout the services. Walter Reed hospital is using yoga to combat PTSD. Submariners and Camp Lejeune marines are using "Warrior Mind Training" to improve mental focus. And the Army is spending $4 million to study various alternative-therapies, including a research project that examines "how holing and petting an animal can treat PTSD."

Study Shows Growing Use of Complementary and Alternative Medicine

Research reported on the Website of the National Center for Complementary and Alternative Medicine (NCCAM) at the

National Institutes of Health (nccam.nih.gov) shows a trend toward greater use of complementary and alternative medicine by adults and children. According to a December 10, 2008, press release announcing the research results:

> Approximately 38 percent of adults in the United States aged 18 years and over and nearly 12 percent of U.S. children aged 17 years and under use some form of complementary and alternative medicine (CAM), according to a new nationwide government survey. This survey marks the first time questions were included on children's use of CAM, which is a group of diverse medical and health care systems, practices, and products such as herbal supplements, meditation, chiropractic, and acupuncture that are not generally considered to be part of conventional medicine.
>
> The survey included questions on 36 types of CAM therapies commonly used in the United States—10 types of provider-based therapies, such as acupuncture and chiropractic, and 26 other therapies that do not require a provider, such as herbal supplements and meditation.
>
> The 2007 survey results, released in a National Health Statistics Report by NCHS, are based on data from more than 23,300 interviews with American adults and more than 9,400 interviews with adults on behalf a child in their household. The 2007 survey is the second conducted by NCCAM and NCHS—the first was done as part of the 2002 NHIS.

"The 2007 NHIS provides the most current, comprehensive, and reliable source of information on Americans' use of CAM," said Josephine P. Briggs, M.D., director of NCCAM. "These statistics confirm that CAM practices are a frequently used component of Americans' health care regimens, and reinforce the need for rigorous research to study the safety and effectiveness of these therapies. The data also point out the need for patients and health care providers to openly discuss CAM use to ensure safe and coordinated care."

Comparison of the data from the 2002 and 2007 surveys suggests that overall use of CAM among adults has remained relatively steady—36 percent in 2002 and 38 percent in 2007. However, there has been substantial variation in the use of some specific CAM therapies, such as deep breathing, meditation, massage therapy, and yoga, which all showed significant increases.

The most commonly used CAM therapies among U.S. adults were

- Non-vitamin, non-mineral, natural products (17.7 percent) Most common: fish oil/omega 3/DHA, glucosamine, echinacea, flaxseed oil or pills, and ginseng
- Deep breathing exercises (12.7 percent)
- Meditation (9.4 percent)
- Chiropractic or osteopathic manipulation (8.6 percent)
- Massage (8.3 percent)
- Yoga (6.1 percent)

Adults used CAM most often to treat pain including back pain or problems, neck pain or problems, joint pain or stiffness/other joint condition, arthritis, and other musculoskeletal conditions. Adult use of CAM therapies for head or chest colds showed a marked decrease from 2002 to 2007 (9.5 percent in 2002 to 2.0 percent in 2007).

Consistent with results from the 2002 data, in 2007 CAM use among adults was greater among:

- Women (42.8 percent, compared to men 33.5 percent)
- Those aged 30-69 (30-39 years: 39.6 percent, 40-49 years: 40.1 percent, 50-59 years: 44.1 percent, 60-69 years: 41.0 percent)
- Those with higher levels of education (Masters, doctorate or professional: 55.4 percent)
- Those who were not poor (poor: 28.9 percent, near poor: 30.9 percent, not poor: 43.3 percent)
- Those living in the West (44.6 percent)
- Those who have quit smoking (48.1 percent)

Overall, CAM use among children is nearly 12 percent, or about 1 in 9 children. Children are five times more likely to use CAM if a parent or other relative uses CAM. Other characteristics of adult and child CAM users are similar – factors such as socioeconomic status, geographic region, the number of health conditions, the number of doctor visits in the last 12 months, and delaying or not receiving conventional care because of cost are all associated with CAM use.

Among children who used CAM in the past 12 months, CAM therapies were used most often for back or neck pain, head or chest colds, anxiety or stress, other musculoskeletal problems, and Attention Deficit/Hyperactivity Disorder (ADD/ADHD).

The most commonly used CAM therapies among children were

- Non-vitamin, non-mineral, natural products (3.9 percent) Most common: echinacea, fish oil/omega 3/DHA, combination herb pill, flaxseed oil or pills, and prebiotics or probiotics
- Chiropractic or osteopathic manipulation (2.8 percent)
- Deep breathing exercises (2.2 percent)
- Yoga (2.1 percent)

The full report and downloadable graphics are at nccam.nih.gov/news/camstats/.

CONSUMER INFORMATION

California Doctors Oppose Waiting Room Sign Proposal

Staff writer Cheryl Clark wrote in the April 13, 2009, online ***HealthLeaders Media***, (www.healthleadersmedia.com) that, “California doctors may soon have to post the state Medical Board's name, Web site, and phone number in their waiting rooms, so

their patients know where to complain if they're not happy with care." Next month, she continues:

> The Medical Board of California will consider requiring any of the state's 125,000 physicians who have waiting areas to "prominently" post a "large, clearly visible sign" 8.5 x 11 inches in 24-point type that says:
>
> **Medical doctors are licensed and regulated by the Medical Board of California.**
> **www.mbc.ca.gov**
> **(800) 633-2322**
>
> The Medical Board may allow doctors, especially those without waiting rooms, such as radiologists or pathologists, to notify patients in other ways, such as with a brochure or letter that includes similar wording, which could be sent with bills.
>
> California would not be alone with such a posting requirement for doctors. Texas, Kansas, Georgia, and Idaho are among other states that have similar requirements.
>
> "In my experience, many people do not know about the Medical Board of California's existence or enforcement jurisdiction," says attorney Julianne D'Angelo Fellmeth. Fellmeth was appointed by the board as "independent enforcement monitor," a position created by the Legislature, to conduct a two-year examination of the board's oversight process.
>
> When they hear of a physician's alleged misconduct, board investigators first look for court filings. "They routinely come across people who have sued doctors for malpractice but who have not filed a complaint with the Medical Board," says Fellmeth, of the Center for Public Interest Law at the University of San Diego. ***(Ed. Note: Fellmeth is also a member of CAC's Board of Directors and a recipient of the Ben Shimberg Public Service Award.)***
>
> A physician's failure to provide proper notice of the board's authority could come with penalties or fines, Fellmeth said.
>
> Medical Board member Mary Lynn Moran, MD, says she is likely to vote for a posting requirement. "If signage is required by cab drivers, it should certainly be expected of physicians to let the public know that they are held to a set of standards and regulated by the state," says the Woodside plastic surgeon. "Consumers have the right to know that if they do not feel that their physician is acting professionally, that the overseeing licensing agency should be informed of their concerns."
>
> The exact language of the board's proposed rule will be issued in several weeks, says board spokeswoman Candis Cohen. Before the rule takes effect, the full board will have to approve it, and then go through a regulatory process of up to six months.
>
> Expectedly, some California doctors are not enthused. Ted Mazer, MD, a CMA trustee, thinks the regulation "…is a stupid waste of time. I think patients already know there's a

Medical Board," he said. "Patients will see it, and say 'OK. Whatever.' But I don't think they'll remember that's where they have to go if they have a problem later."

But he also objects because he thinks the posting could encourage patients to report something to the disciplinary agency "that might be far more easily managed with a conversation with the patient."

Mazer, a San Diego ear, nose, and throat specialist, also questioned Fellmeth's motives. "Julie Fellmeth seems to feel that if she doesn't currently have something to slap doctors in the face with, she should find something," he says.

Mazer says he would only support such a requirement if health plans and others who make decisions about patient care as well as attorneys have to post such notices as well, referring patients to the Department of Managed Health Care or the State Bar of California respectively.

James Hay, MD., the CMA's liaison to the Medical Board of California, also thinks the proposed rule is unreasonable.

"The doctor patient relationship from the start should be based on mutual trust," he says. Yet this proposed rule "does not seem to me to be a worthwhile thing to foster that doctor-patient relationship," says Hay, an Encinitas family practitioner. If the Medical Board is supposed to educate the public, but hasn't done it, "that's the medical board's problem," he says. "The Medical Board shouldn't ask the physicians to do it for them." There is enough legal room for such a regulation. A legislatively-mandated report last November by the California Research Bureau noted that a 1998 state law called for the Medical Board to require that doctors notify patients that they practice with oversight from the state. While many other California consumer protection agencies did pass such rules, including those that license architects, auto repair shops, pharmacists, engineers, surveyors, and pest control companies, the Medical Board "has neither adopted nor proposed such regulations," the bureau report said.

That's because of another 10-year-old law, which suggested doctors could satisfy the requirement by wearing a nametag showing their type of practice and license status. Fellmeth says that view is now discounted. Besides, wearing a nametag still doesn't tell patients that the name of the agency to complain to is the Medical Board.

Fellmeth uses the example of the November 2007 death of rapper Kanye West's mother, Donda, one day after being operated on Los Angeles plastic surgeon Jan Adams.

"If Donda had known about the Medical Board and gone to the board's Web site, she would have seen two medical malpractice judgments of at least $200,000 against Adams. He had been arrested and convicted twice of driving while intoxicated, grounds the medical board was using then in an effort to revoke his license," Fellmeth says. Adams surrendered his license effective April 8.

The CMA currently supports a bill that would require health practitioners to disclose their license type and educational degrees, as well as their board certification. But the CMA bill stops short of requiring any mention that the Medical Board's name or phone number be given to patients, Fellmeth says.

"If doctors voluntarily notified patients of the board's existence, we would not need the regulation," Fellmeth says. "But they do not. And it is the law."

Announcements

CAC is now a membership organization *and we invite your board to join. For information about the benefits that are available to our members, and for a membership enrollment form, please see pages 25 and 26 of this issue or go to www.cacenter.org/files/membership.pdf.*

Our 2009 Annual Meeting *will be held on Wednesday, Thursday, and Friday, October 28, 29, and 30, 2009, at the Royal Plaza Hotel in Lake Buena Vista, Orlando, Florida. For more information please see www.cacenter.org/cac/meetings.*

CAC is Now a Membership Organization

We are pleased to announce that we are offering memberships to state health professional licensing boards and other oversight agencies. **We invite your agency to become a CAC member, and request that you put this invitation on your board agenda at the earliest possible date.**

As you may know, CAC is a not-for-profit, 501(c)(3) tax-exempt service organization dedicated to supporting public members serving on healthcare regulatory and oversight boards. Many of you are familiar with our organization and the services we provide. Over the years, it has become apparent that our programs, publications, meetings and services are of as much value **to the boards themselves** as they are to the public members. Therefore, the CAC board has decided to offer memberships to health regulatory and oversight boards in order to allow the boards to take full advantage of our offerings.

We provide the following services to boards that become members:

(1) One **free** electronic subscription to our highly regarded quarterly newsletter, **CAC *NEWS & VIEWS*** (current subscribers receive a prorated credit);

(2) A **10% discount** for **all** of your board members and **all** of your staff who register for CAC meetings, including our fall annual meeting;

(3) **Free** electronic copies of all available CAC publications;

(4) A **free** review of your board's website in terms of its consumer-friendliness, with suggestions for improvements;

(5) **Discounted rates** for CAC's **onsite** training of your board on how to most effectively utilize your public members, and on how to connect with citizen and community groups to obtain their input into your board rule-making and other activities;

(6) Assistance in **identifying qualified individuals** for service as public members.

We have set the annual membership fee as follows:

Individual Governmental Agency	$275.00
Governmental Agency responsible for:	
2 – 9 regulated entities/professions	235.00 each
10 – 19 regulated entities/professions	225.00 each
20+ regulated entities/professions	215.00 each
Association of regulatory agencies or organizations	450.00
Non-Governmental organization	375.00

Please complete the following form if your board or agency is ready to become a member of CAC, or if you would like answers to any questions you may have before deciding whether to join. Mail the completed form to us, or fax it to (202) 354-5372.

CAC Membership Enrollment Form

A) **YES**, our agency would like to join CAC:

Name of Agency:	
Name of Contact Person:	
Title:	
Mailing Address:	
City, State, Zip:	
Direct Telephone Number:	
Email Address:	

PAYMENT OPTIONS:

1) Make a check payable to CAC for the appropriate amount. (Current subscribers receive a pro-rated credit. If you are already a subscriber, call us at (202) 462-1174 before sending a check);
2) Provide us with your email address, so that we can send you a payment link that will allow you to pay using PayPal or any major credit card (including American Express);
3) Provide us with a purchase order number so that we can bill you. Our Federal Identification Number is 52-1856543;

Purchase order number:	

Or

4) Complete the following form if paying with Visa or MasterCard:

Name:	
Credit card number:	
Expiration date and Security Code:	
Billing Address:	
City, State, Zip:	
Security Code:	

Signature Date

B) **PERHAPS** our agency will join CAC.

____ We would like to discuss this with you. Please call:

______________________________ at ____________________

(name and title) (telephone number)