News & Views

Citizen Advocacy Center

First Quarter, 2012 A Health Care Public Policy Forum Volume 24 Number 1

ANNOUNCEMENTS

On Thursday and Friday, October 25 and 26, 2012, CAC will hold its 2012 annual meeting in St. Petersburg, Florida. *Please visit www.cacenter.org in early May for more details and registration materials.*

On Tuesday, June 12, 2012, CAC will conduct a meeting entitled "The Regulatory Management of Chemically Dependent Health Care Practitioners: Reporting to Licensing Boards" at our offices in Washington, DC. *Please visit www.cacenter.org in early April for more details and registration materials.*

On Wednesday, June 13, 2012, CAC will conduct a meeting entitled "Continuing Professional Development: Demonstrating Current Competence" at our offices in Washington, DC. *Please visit www.cacenter.org in early April for more details and registration materials.*

CAC is now a membership organization *and we invite your board to join. More information is at http://www.cacenter.org/cac/membership.*

Although we encourage you to receive our newsletter by becoming a CAC member, you may still subscribe to our newsletter without becoming a member. *More information is at http://www.cacenter.org/view/newsletter.*

CAC offers consulting services. *More information is at http://www.cacenter.org/cac/consultant_services.*

SCOPE OF PRACTICE

Connecticut Adopts Process for Evaluating Scope of Practice Changes

Public Act 11-209, *An Act Concerning the Department of Public Health's Oversight Responsibilities Relating to Scope of Practice Determinations for Health Care Professions*, establishes a process for the submission and review of requests from health care professions seeking to revise or

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establish a scope of practice prior to consideration by the General Assembly. Under the provisions of this act, scope of practice review committees may review and evaluate these requests and provide findings to the joint standing committee of the General Assembly having cognizance of matters relating to public health. The Department of Public Health (DPH) is responsible for receiving requests and for establishing and providing support to the review committees, within available appropriations.

As of October 2011 the following requests had been reported by the DPH:

> The Connecticut Academy of Physicians Assistants is requesting specific amendments to the physicians' assistant practice act as follows:
>
> - Eliminate the ratio provision of the number of PAs a physician can supervise;
> - Eliminate the requirement that a supervising physician must personally review the physician assistant's practice at least weekly or more frequently; and
> - Eliminate the requirement that a supervising physician must co-sign all prescriptions and orders for Schedule II and III drugs within 24 hours.

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The Connecticut Children's Medical Center is requesting an amendment to the practice act for respiratory care practitioners to allow them to function as part of an extracorporeal membrane oxygenation (ECMO) clinical team. CCMC has also submitted a request for an exemption from the scope of practice determination process and a request that the department issue a declaratory ruling confirming CCMC's belief that respiratory care practitioners can already perform needed functions as part of an ECMO clinical team, thus obviating the need for a scope of practice determination.

The Connecticut Dental Hygienists Association is requesting to establish an Advanced Dental Hygiene Practitioner (ADHP) – a mid-level oral health provider, who will provide an expanded scope of oral health services to underserved individuals in public health settings. The ADHP would be an "endorsement" to a current dental hygiene license.

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The Connecticut Naturopathic Physicians Association is requesting an amendment to the naturopathic practice act to give naturopathic doctors the ability to use nutrients by all forms of administration. The current scope of practice includes treatment by natural substances and external applications.

The Connecticut Dental Assistants Association is requesting to increase the scope of practice for dental assistants in public health and provide settings to allow for the education, training and recognition of an expanded function dental auxiliary (EFDA) in Connecticut.

The Connecticut State Dental Association is requesting to expand the scope of practice for dental hygienists in public health and institutional settings to include Interim Therapeutic Restorations with hand instruments.

The Connecticut State Electrology Association is requesting to expand the scope of practice of licensed electrologists to include the removal of body and facial hear through the use of laser or light-based devices.

The CT Sleep Society is requesting to establish a new licensure program and scope of practice for polysomnographic technicians and polysomnographic technologists and to restrict the practice of polysomnography to licensed technicians and technologists.

The practice of homeopathy is currently limited to licensed homeopathic physicians (MDs). Homeopathy for Connecticut is requesting to expand the practice of homeopaths, and to call themselves homeopaths.

Quinnipiac University is requesting an amendment to the radiologist assistant scope of practice to eliminate the requirement that radiologist assistants perform certain procedures under the personal supervision of a licensed physician.

For more information, visit:
http://www.ct.gov/dph/cwp/view.asp?a=3121&q=486562&PM=1&dphNav=%7C.

New York Times Finds Scope of Practice Newsworthy

On October 1, 2011, *The New York Times* ran an article about the controversy over nurses with doctorates calling themselves "doctor." http://www.nytimes.com/2011/10/02/health/policy/02docs.html?_r=1&pagewanted=print

A few days later, *The Times* published the following Letter to the Editor, which draws attention to the fact that issues involving scope of practice and professional titles impact other professions, in addition to nursing.

R. Scott Ward, PT, PhD, President American Physical Therapy Association, wrote in part:

To provide accurate information to consumers, the American Physical Therapy Association has taken a proactive approach and provides clear guidelines for physical therapists regarding the use of the title "Doctor."

In the October 1, 2011, article "When the Nurse Wants to Be Called 'Doctor'" by Gardiner Harris, physicians claim that using the term "doctor" by physical therapists could lead to patient confusion.

To provide accurate information to consumers, the American Physical Therapy Association has taken a proactive approach and provides clear guidelines for physical therapists regarding the use of the title "Doctor." These guidelines state that physical therapists, in all clinical settings, who hold a doctor of Physical Therapy Degree (DPT), shall indicate they are

physical therapists when using the title "Doctor" or "Dr.," and shall use the titles in accord with jurisdictional law.

The entire letter can be found at:
http://www.apta.org/Media/Letters/2011/10/5/.

Chiropractor Endorses Multidisciplinary Practice

Mark Sanna, DC, a member of the Chiropractic Summit, the ACA Governor's Advisory Board, and a board member of the Foundation for Chiropractic Progress, and the president and CEO of Breakthrough Coaching, wrote an article in *Chiro.com – Your Online Chiropractic Community* advocating a multidisciplinary practice model combining a variety of services to patients. He wrote, in part:

> A multidisciplinary practice provides both allopathic and holistic therapies with a two-pronged "corrective" and "wellness" approach. Today, the multidisciplinary practice is the cutting-edge battleground of healthcare reform, integrating chiropractic with mainstream healthcare.
>
> There is a clear scope of practice between allopathic and chiropractic healthcare, and multidisciplinary practices provide patients with the best of both disciplines. It is time for healthcare practitioners of all disciplines to make their services more accessible to patients in one-stop, holistic-allopathic blended healthcare practices that honor the disciplines of all practice members involved…
>
> One-stop shopping, where the patient receives chiropractic, medical, and physical therapy services, is an important trend to recognize. The trend toward multidisciplinary practice consolidation extends beyond the combination of physical medicine services under one roof.
>
> One-stop shopping, where the patient receives chiropractic, medical, and physical therapy services, is an important trend to recognize.
>
> Multidisciplinary practices can include multiple healing modalities, including massage, podiatry, nutrition, and acupuncture. This results in a second trend, known as diversification.
>
> Multidisciplinary practices consolidate location and the variety of services delivered. This highly coordinated, cost-effective manner of delivering patient care is defining the practice of today and the future…
>
> A true multidisciplinary practice provides a team approach to healthcare. You deliver chiropractic, the medical physician provides upgraded diagnostic capabilities, and the physical therapist offers

active care rehabilitation. Once your legal and operational infrastructure is in place, you are ready to hire your professional staff.

When you operate your practice correctly, legally, and with proper professional guidance, adopting a multidisciplinary model will grow your practice considerably. Your increased scope of services can attract more patients and result in a larger patient volume…

As a profession, we have attempted to change the healthcare delivery system of our nation for more than 100 years, working from outside the system.

By embracing medical and alternative healthcare professions within a multidisciplinary practice setting, chiropractic can change the way our nation embraces it as a healing modality.

The entire article can be found at: http://www.chiroeco.com/chiropractic/news/11757/1598/the%20multidisciplinary%20model/.

Nurse Practitioners Improve Discharge but Not Readmissions

Research at Massachusetts General Hospital found that involving nurse practitioners improves the discharge process, and results in more follow-up appointments, and better patient attendance at follow-up appointments. However, nurse practitioner involvement did not affect 30-day readmission rates or emergency department visits.

The study was published in the Journal of Hospital Medicine at http://onlinelibrary.wiley.com/doi/10.1002/jhm.924/abstract.

Physician-Nurse Teams Reduce Surgical Complications

Research published in the *Archives of Surgery* found that physician-nurse teams at 42 Veterans Health Administration hospitals reduced surgery-related complications from 90 out of 1,000 surgeries to 75. Hospitals using teamwork reduced patient deaths by 15 percent, compared with a 10 percent reduction at hospitals not using teamwork.

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The surgical teams used a checklist to discuss the case prior to surgery. They also conduct debriefings after the surgery, sometimes with the patient.

For more information, see: http://archsurg.ama-assn.org/cgi/content/abstract/146/12/1368.

Home Birth Summit Produces Nine Consensus Statements

A multi-disciplinary group met in October 2011 at the Home Birth Consensus Summit at the Airlie Center in Warrenton, Virginia. The consensus statements promote patient autonomy and encourage collaboration among maternity care professionals. Members of the American College of Obstetricians and Gynecologists, however, questioned the safety of home births and the qualifications of certified nurse midwives.

The consensus statements include:

- We uphold the autonomy of all childbearing women.
- We believe that collaboration within an integrated maternity care system is essential for optimal mother-baby outcomes.
- We are committed to an equitable maternity care system without disparities in access, delivery of care, or outcomes.
- It is our goal that all health professionals who provide maternity care in home and birth center settings have a license that is based on national certification that includes defined competencies and standards for education and practice.
- We believe that increased participation by consumers in multi-stakeholder initiatives is essential to improving maternity care…
- Effective communication and collaboration across all disciplines caring for mothers and babies are essential for optimal outcomes across all settings.
- We are committed to improving the current medical liability system, which fails to justly serve society, families, and health care providers…
- We envision a compulsory process for the collection of patient level data on key process and outcomes measures…
- We recognize and affirm the value of physiologic birth for women, babies, families and society and the value of appropriate interventions based on the best available evidence to achieve optimal outcomes for mothers and babies.

Effective communication and collaboration across all disciplines caring for mothers and babies are essential for optimal outcomes across all settings.

For more, see: http://www.medscape.com/viewarticle/752896.

Low-risk Pregnancies Don't Require Hospitalization

Research published in the *British Medical Journal* in November 2011 found little difference in complications among low-risk pregnancies

delivered in a hospital versus home or a birthing center. The authors conclude that women with uncomplicated pregnancies should be able to choose where to give birth.

Sixty percent of deliveries in Britain are performed by midwives. About a quarter of deliveries in the Netherlands occur at home.

For more, go to: http://www.bmj.com/press-releases/2011/11/24/women-pregnancy-low-risk-complications-can-safely-be-offered-choice-where-

Nurses Critical to Patient Safety

An article in the Agency for Healthcare Research and Quality PSNet Patient Safety Primer discusses the pivotal role of nurses in patient safety and healthcare outcomes. It references several studies that demonstrate "the link between nurse staffing ratios and patient safety, documenting an increased risk of patient safety events, morbidity, and even mortality as the number of patients per nurse increases." In addition to nurse staffing ratios, overall workload, and nursing skill mix and on the job training influence patient outcomes.

For more, visit: http://psnet.ahrq.gov/primer.aspx?primerID=22.

Maine Dental Board Restricts Dental Hygiene Pilot

Ignoring the recommendations of the Federal Trade Commission and the Governor, the Maine Board of Dental Examiners voted in December 2011 to restrict the types of x-rays independent practice dental hygienists (IPDH) can use during a pilot project to evaluate expanding IPDH scope to administer x-rays in underserved areas without the direct supervision of a dentist. The legislature gave the board responsibility for developing the rules for the pilot project. The rules restrict IPDHs to bitewing and periapical x-rays without having a dentist present.

Both the Governor and the Federal Trade Commission advised the board that the restrictions were excessive.

According to an article on the subject by Kathy Kincade on DrBicuspid.com, both the Governor and the Federal Trade Commission advised the board that the restrictions were excessive and could jeopardize the usefulness of the pilot project. The state dental hygiene association is considering legal action to reverse the board's decision.

For more, see: http://www.drbicuspid.com/index.aspx?sec=sup&sub=hyg&pag=dis&ItemID=309389&wf=33.

CONTINUING PROFESSIONAL DEVELOPMENT

ARBO Expands Review of Accredited CE Courses

Editorial Note: According its newsletter the Green Sheet, the Association of Regulatory Boards of Optometry (ARBO) will more closely monitor compliance with its guidelines for accredited CE courses:

> COPE (*Council on Optometric Practitioner Education*) is expanding its On-Site Review Program to allow all COPE Reviewers to perform On-Site Reviews of every COPE-Accredited course they attend. The goal of the On-Site Review program is to obtain objective information that can be used by the COPE Committee to determine compliance with COPE's guidelines. This is an important element in COPE's ongoing effort to assure optometric CE with the highest integrity that is free from commercial bias for our Member Boards…
>
> All COPE Reviewers must complete two new online training modules before they are allowed to perform an On-Site Review. The new modules were developed to train reviewers on some of the recent changes in the COPE review process. One module gives information on changes that have taken place as a result of the implementation of the Standards for Commercial Support, and the second module demonstrates how to conduct an On-Site Review and report the results back to COPE.
>
> When performing an On-Site Course Review, reviewers are asked whether proprietary interest (or lack thereof) is disclosed by the lecturer and if the course content is free from commercial bias. Reviewers are also asked if the outline that is handed out is relevant to the course content and if the category that was assigned to the course matches the majority of the course content. Reviewers performing an On-Site Program Administration Review are asked to evaluate documentation, facilities and compliance with COPE's Standards for Commercial Support. Some of the specific questions on the review form include whether a certificate of attendance with all the required information was handed out, whether a representative of a commercial supporter was present during the course, and if there was any product promotion done in the classroom…

All COPE Reviewers must complete two new online training modules before they are allowed to perform an On-Site Review.

The complete article can be found at:
http://www.arbo.org/greensheets/Greensheet_Fall_2011.pdf

ABMS Now Reports Physicians' Maintenance of Competence Status

In October 2011 The American Board of Medical Specialties announced that it will publicly report physicians' status in meeting maintenance of competence requirements. According to its October 11, 2011, press release:

> The American Board of Medical Specialties (ABMS) announced today that it has begun reporting publicly whether physicians who are Board Certified by one or more of the 24 ABMS Member Boards are meeting the ABMS Maintenance of Certification® (ABMS MOC®) program requirements established by their certifying Board(s). The public reporting initiative is being rolled out during the next year beginning with seven Member Boards, including the American Board of Dermatology, American Board of Family Medicine, American Board of Nuclear Medicine, American Board of Otolaryngology, American Board of Physical Medicine and Rehabilitation, American Board of Plastic Surgery and American Board of Surgery. The remaining 17 Member Boards will make the MOC status of their Board Certified physicians available in August 2012 or sooner.

We're honoring our pledge of increased transparency to the public by providing easy access to important information about individual physicians.

Some Member Boards have already been reporting the MOC status of their Board Certified physicians in alternate formats. For the first time, however, ABMS will serve as the central repository for the MOC status of physicians from all 24 ABMS Member Boards, which will be reported publicly in the same format. The MOC status of physicians Board Certified by an ABMS Member Board(s) will also be displayed by ABMS licensees, official display agents and on http://www.CertificationMatters.org.

> "We're honoring our pledge of increased transparency to the public by providing easy access to important information about individual physicians," said Kevin B. Weiss, MD, ABMS President and CEO. "This is a significant milestone in ABMS history. The public can be confident that physicians who are meeting the requirements of the ABMS MOC program are committed to lifelong learning and ongoing self-evaluation."…
>
> The types of tools and programs that physicians can use to meet the requirements of an MOC program vary by specialty. ABMS Member Boards tailor their MOC programs to the needs of their specific medical specialties.

For more information, see:
http://www.abms.org/News_and_Events/Media_Newsroom/Releases/release_Announcing_PublicReportingMeetingMOC_10112011.aspx.

Federation of State Medical Boards Circulates Draft Policy on Reentry to Practice

The Federation of State Medical Boards (FSMB) has solicited comments on a draft report from the Special Committee on Reentry to Practice. The report will be presented to the membership at the FSMB's annual meeting in April. The draft report defines the role of member boards in physician reentry to practice in five areas:

- Education and Communication Issues
- Determining Fitness to Reenter Practice
- Mentoring Practitioners Who Want to Reenter the Workforce
- Improving Regulation of Licensed Practitioners Who Are Clinically Inactive
- The Relationship between Licensure and Specialty Certification

The report recommends that boards engage in case-by-case assessment of physicians' competence to reenter practice. Physicians seeking reentry should document their future scope of practice plans, including reflective self-assessment plans, completion of "objective knowledge and skills assessments to identify learning opportunities and guide improvement activities," and documentation of successful performance in practice. Several of these recommendations mirror the FSMB's Maintenance of Licensure components.

Maine Adds Exam for Relicensure

The Federation of State Medical Boards (FSMB) reports in its May/June/July 2011 *Newsline*, the Maine Board of Licensure in Medicine will now require an examination on rules, policies and laws for licensure renewal. It is a 30-question open book exam based on review materials provided by the board, which considers the exam to be an "information dissemination device." Licensee reaction to the exam has been surprisingly positive.

Licensee reaction to the exam has been surprisingly positive.

More information about the exam can be found at www.docboard.org/me/me_home.

PATIENT SAFETY

Consumers Union Surveys Consumers about Patient Safety

The Consumer Reports National Research Center conducted a nationwide telephone survey in January 2011 posing questions about consumers' experience with medical errors. Among the survey's findings:

- Six in ten respondents said it is *very* or *somewhat* common for patients to be harmed by a medical error at a hospital.
- Forty-eight percent said that serious harm is *very* or *somewhat* common.
- Sixty-two percent expressed *high* or *moderate* concern that someone in the family might be harmed by a medical error in a hospital.
- Despite these findings, 78% of respondents believe hospitals are *very* or *somewhat* effective at preventing medical errors.
- A majority of respondents believe they should have ready access to information about complaints filed against hospitals and doctors and malpractice histories.
- Half of respondents believe doctors whose licenses have been restricted should be removed from patient care until his or her license is fully reinstated.

Consumers Union has developed a Model Medical Harm Disclosure Act.

Consumers Union has developed a Model Medical Harm Disclosure Act (which can be found at model medical error reporting law), aimed at improving the rate of hospital compliance with medical error reporting laws and broadening reporting requirements to include all errors, not just "Never Events."

More information is available at: http://pressroom.consumerreports.org/pressroom/2011/03/consumer-reports-poll-finds-high-levels-of-concern-about-medical-harm-support-for-public-ratings-on-.html, and at www.safepatientproject.org.

Mid-Career Surgeons Safer

The *British Medical Journal* reported research findings that thyroid surgeons between the ages of 35 and 50 are safer care than surgeons younger and older than those ages. Researchers studied 3,574 thyroidectomies performed by 28 surgeons during one year. They documented two common complications of thyroid surgery 48 hours and six months after the procedure.

Patients were more likely to experience one of these complications if their surgeons were inexperienced or had been in practice more than 20 years. Surgeons with 5 – 20 years experience since graduating from school had better outcomes.

For more, go to: http://group.bmj.com/group/media/latest-news/surgeons-aged-between-35-and-50-provide-the-safest-care/?searchterm=surgeon%20age.

CONSUMER INFORMATION

Advocates Ask HRSA to Restore the NPDB Public Access File

In September 2011 the Health Resources Services Administration (HRSA) removed the Public Use File from its National Practitioner Data Bank Web site. The Public Use File contains aggregate data about disciplinary actions taken by licensing boards and health care facilities. Unlike the Data Bank, which cannot be accessed by the public, the Public Use File does not identify disciplined practitioners by name. Nevertheless, HRSA removed the Public Use File when it was alleged that it is possible to identify individual practitioners from the data. The Agency has promised to restore the File after it has been modified to better protect confidentiality.

There was an outcry from consumer advocates and health journalists when Public Use File was removed. Journalists complained to HRSA Director, Mary Wakefield and then appealed to HHS Secretary Kathleen Sebelius to restore access to the File. According to a press release from the Association of Health Care Journalists:

There was an outcry from consumer advocates and health journalists when Public Use File was removed.

> The Association of Health Care Journalists and five other journalism groups appealed to Health and Human Services Secretary Kathleen Sebelius to intervene in the dispute over the Public Use File of the National Practitioner Data Bank and restore access to this important data tool.
>
> AHCJ was joined in its letter to Sebelius by Investigative Reporters and Editors, the Society of Professional Journalists, the National Association of Science Writers, the Reporters Committee for Freedom of the Press, and the National Freedom of Information Coalition. The groups have more than 15,000 members.
>
> The U.S. Health Resources and Services Administration removed the Public Use File (PUF) from the data bank website earlier this month because officials believe it was used to identify physicians inappropriately…

"We do not dispute that federal law precludes the administration from sharing confidential information from data bank reports, including the person being reported and the institution filing the report. We disagree with HRSA that the Public Use File, removed from the web earlier this month, did this."…

The letter also criticized HRSA's research protocol under which reporters can now request data from the data bank as intrusive and unfair… "We find it troubling that a federal agency now wants to judge the quality of reporters' stories and make individual decisions about which one is worthy –perhaps putting officials in the position of denying requests that may make HRSA or the data bank look poor," the letter said. "We don't see any provisions in the act governing the data bank that gives HRSA the authority to deny research data as long as it doesn't identify individuals."

The groups said they stood ready to meet with Sebelius and work with her on a solution that will provide continued access to the Public Use File…

The complete press release and additional information are available at: http://www.healthjournalism.org/about-news-detail.php?id=129.

In early November 2011, HHS restored public access to the data bank, with certain restrictions.

In early November 2011, HHS restored public access to the data bank, with certain restrictions. Users will have to agree not to use the information in the NPDB to identify individual doctors who have been sued or disciplined by a licensing board. On November 14, 2011, Consumer Union's *Safe Patient Project* issued a press release calling for full public access to the federal data banks. CU said, in part:

The public should have full access to a government database on problem doctors, including the names of physicians with a history of harming patients, according to Consumers Union's Safe Patient Project…

"When information held by the government is declared 'public' there should be no strings attached to the use of that data," said Lisa McGiffert, director of Consumers Union's Safe Patient Project (www.SafePatientProject.org). "The elephant in the room during this whole controversy is that most of this information is public in other places and should be public at the NPDB. It's time to provide the public full access to this critical information, including the names of doctors who have been disciplined by state licensing boards or sued for failing to provide safe care."

A January 2011 Consumer Reports National Research Center poll found overwhelming support for giving the public access to the information the federal government collects on doctors. Almost 9 in 10 respondents (88%) said the public should have access to federally collected information about problems with doctors.

The Public Use Data File of the NPDB has been used for the past 15 years by researchers to analyze trends and by reporters to provide the public with essential information about medical malpractice, medical licensing disciplinary actions, and peer review actions. It does not disclose doctor-specific information. Under current law, HHS must make a Public Use Data File available while keeping the identity of doctors confidential. Hospitals, insurers, state licensing boards and other health care entities are given access to the full information (including doctors' names) so they can check it when doctors apply for licenses and privileges to practice.

The public should have the same access to this information as hospitals and state licensing boards.

"The public should have the same access to this information as hospitals and state licensing boards," said McGiffert. "Because doctors often work in multiple states, losing a license in one state might not translate to losing a license in another. One of the original purposes of the doctor database was to keep track of doctors with licenses in multiple states. Currently, except for checking every state's medical board website, the public has no central source to find out this critical patient safety information."…

For more, see:
http://safepatientproject.org/2011/11/consumers_union_public_should.html.

Editorial Note: On February 3, 2012, Julianne D'Angelo Fellmeth, Administrative Director, Center for Public Interest Law, University of San Diego School of Law (and CAC Board Member) wrote the follow letter to the Medical Board of California. Upon receipt of the letter, the Medical Board of California put this issue on its May 3 – 4, 2012, meting agency:

My name is Julie D'Angelo Fellmeth and I am the Administrative Director of the Center for Public Interest Law (CPIL) at the University of San Diego School of Law. For 30 years, CPIL has monitored California state agencies that regulate business, professions, and trades – including the Medical Board of California. I also served as the Medical Board's Enforcement Monitor from 2003 – 2005, so I am quite familiar with the Board's enforcement program.

My comment today relates to a complaint made to the Governor by Public Citizen, a Washington, D.C. – based public interest organization.

Last year, Public Citizen mined the information at the National Practitioner Data Bank, which is a national database created by the federal government 20 years ago to track licensing, discipline, medical malpractice, and hospital disciplinary action / information on physicians and other health care practitioners.

A number of entities – including state medical boards, hospitals and HMOs, and insurance carriers – are required to report certain information to the NPDB. The goal is to prevent incompetent physicians from roaming from state to state, lying about their records, and securing licensure in a new state.

The goal is to prevent incompetent physicians from roaming from state to state, lying about their records, and securing licensure in a new state.

Last fall, Public Citizen alleged that this Board had failed – over the last 20 years – to take disciplinary action against a good number of California-licensed physicians who had been disciplined by hospitals through the peer review process and were reported to the NPDB.

This is of great concern – because we know that doctors who run hospitals do not lightly or frequently take disciplinary action against their fellow doctors. Public Citizen also reported that about 100 of these doctors were labeled "imminent risks" by the hospitals that reported them – yet they were not disciplined by this Board.

The Governor's Office was concerned about this, and your staff did an analysis of Public Citizen's allegations. According to the minutes of this Board's October 2011 meeting that you approved yesterday, "two-thirds of the cases were past the statute of limitations and had been purged due to retention requirements."

This does not make me feel any better. What I also learned is that your staff only queries the NPDB at point of initial licensure. It does NOT query the NPDB every two years when physicians renew their licenses. If it did, it might pick up these matters before the statute of limitations runs. It costs $4.75 to query the NPDB – that is the cost of a cup of coffee in today's world, and that cost could easily be added to your license renewal fee and enable the Medical Board to query the Data Bank every two years.

What also concerns me is that the decision NOT to query the Data Bank at every renewal was apparently a staff decision, and it was probably made long ago. I have been attending Medical Board

meetings for 25 years (long before the Data Bank was even created), and I have never heard this Board even discuss the NPDB – much less decide not to use it.

I encourage you to look into this as a Board matter – ask your staff to do a cost-benefit analysis of an every-two-years query. Hospitals are required to query the NPDB every two years when they renew privileges – I think you should too.

One last comment: I cannot query the Data Bank on my physician. It is not open to the public. I am counting on you to do that for me, as part of your public protection mandate. That is what the Data Bank is for – and you should take advantage of it.

I cannot query the Data Bank on my physician. It is not open to the public.

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Editorial Note: For the point of view of some in the medical establishment, see this piece of legislation, which would "protect" physicians from mistreatment by the NPDB: http://www.aapsonline.org/index.php/site/article/h.r.2472_health_care_professionals_protection_act_of_2011/.

PAIN MANAGEMENT AND END OF LIFE CARE

CAC Endorses Two Letters from American Pain Foundation

CAC has co-signed the following two letters composed by the American Pain Foundation:

Douglas Throckmorton, MD
Deputy Center Director for Regulatory Programs
Office of the Director, Center for Drug Evaluation and Research
Food and Drug Administration
WO Building 51, Room 6133
10903 New Hampshire Avenue
Silver Spring, MD 20993

Dear Dr. Throckmorton:

The undersigned organizations of the Pain Care Forum (PCF) are concerned about the class-wide Risk Evaluation and Mitigation Strategies (REMS) in development for transmucosal immediate-release fentanyl (TIRF) products. As you know, the Pain Care Forum is comprised of patient, professional, and industry organizations committed to promoting positive national pain policy. An intense discussion in our August meeting brought up a number of questions and concerns about the implication of the various REMS of the recently approved individual TIRFs.

An intense discussion in our August meeting brought up a number of questions and concerns about the implication of the various REMS.

As you know, over two years ago some member organizations of the Pain Care Forum expressed strong concerns that the REMS process for analgesic medications was going to require individual REMS for specific products resulting in confusing and multiple medication guides, multiple provider and patient education requirements and multiple pharmacy processes. The decision to consolidate the extended release and long acting products into a single REMS was a large but partial relief to that concern.

As we become more aware of the various REMS for individual TIRFs recently approved by the Food and Drug Administration (FDA), we note substantial inconsistencies with the discussions now underway between the agency and the Industry Working Group (IWG) about REMS for long-acting and extended-release opioids. These differences run counter to the goal of adopting a consistent approach to mitigating the risks associated with opioids and may seriously impede access to and quality of care. We urge FDA to reconsider these requirements and integrate TIRFs into the planning process for REMS for long-acting and extended-release opioids.

The TIRF class represents a small segment of the opioid market; yet, these medications are a vital therapeutic option for the appropriate patients. Importantly, patients who are prescribed these medications must be opioid-tolerant, that is, simultaneously taking another opioid around-the clock. Typically, the around-the-clock opioid will be a long-acting or extended-release medication. As such, implementing REMS for TIRFs with components that significantly differ from those contemplated for the class of long-acting and extended-release medications may not only limit access but also result in confusion among patients, prescribers, and pharmacists. We believe the approach under consideration by the IWG and FDA for long-acting and extended-release opioids, compared to that for TIRFs, provides a more appropriate balance between patients' needs and concerns about safe and appropriate use.

Taking an entirely different approach to risk minimization for TIRFs is not warranted. The consequences of and strategies to mitigate the risks of abuse and misuse are not different among opioid classes. Further, the need to mitigate overdose risk does not differ among specific products for which patients must be opioid-tolerant, regardless of formulation. In addition, since the individual REMS for several TIRFs have just been approved, a delay in implementation of the class-wide REMS may be warranted. A delay would permit an assessment of what aspects of the various approved REMS are effective in mitigating risks and those that need to be modified. In the interim, however, there are some immediate concerns, which are detailed below that should be addressed:

Patient Education: While we support counseling patients about safe and appropriate use of opioids and other prescription medications, we are concerned about the mandatory use of centrally maintained Patient-Prescriber Agreements (PPAs) as a prerequisite to prescribing and dispensing TIRFs. Any problems with or errors in the central database will result in a denial of medication for patients who are experiencing pain that is often devastating in its intensity and rapid in its onset. We need to assure that there are provisions within the REMS evaluations that will assess in a timely fashion if PPAs are having a negative impact on patient access.

Further, the Medication Guide contemplated for TIRFs is too long and complex to facilitate patient comprehension and medication adherence. The more readable template being considered by FDA and the IWG would be more effective. The Medication Guides, if not coordinated, may offer conflicting information. The potential for confusion is significant since patients prescribed TIRFs would receive two separate Medication Guides as they also will be taking around-the-clock opioids. We are further concerned about requiring prescribers to stock within their offices multiple versions of Medication Guides. This sort of administrative burden may have the unintended consequence of discouraging dissemination of Medication Guides.

The Medication Guides, if not coordinated, may offer conflicting information.

Professional Education: The pain community has appreciated the dialogue with FDA regarding implementation of educational requirements for prescribers and pharmacists. We strongly recommend that the professional educational requirements for TIRFs be incorporated into those for other opioids. Having to complete two highly related educational modules will create an unnecessary burden on prescribers and pharmacists and is unlikely to enhance knowledge. Instead, this burden may lead to prescribing and dispensing practices that are driven by ease of satisfying REMS requirements rather than patient need. In addition, we urge FDA to assure that the Administration's proposal to

utilize Drug Enforcement Administration registration to track fulfillment of the educational requirements for the long-acting and extended-release products also extends to the requirements for the TIRF class.

Pharmacy Management Systems: The requirement to make major modifications to pharmacy management software for a class of products that represents such a small proportion of prescriptions may create a significant disincentive for pharmacies to enroll in TIRF REMS. Insufficient pharmacy participation will disrupt patient access, and could have a negative impact on coordination of care if patients have to go to multiple pharmacies to fill their prescriptions for a TIRF and an around-the-clock opioid. At a minimum, both the effectiveness and potential negative consequences of using the TIRF PPA as a "hard-stop" at the pharmacy should be evaluated within six months of implementation.

Insufficient pharmacy participation will disrupt patient access.

We respectfully request that FDA work closely with the pain community to implement REMS that are consistent with the class-wide program being developed for long-acting and extended-release opioids. The burden of complying with two divergent class-wide REMS has the potential to impede medically appropriate patient access to TIRF products and create confusion for all stakeholders, the very problems a class-wide approach for opioids was intended to prevent.

Sincerely,

American Academy of Pain Management (and others)

October 11, 2011

The Honorable Tom Harkin, Chair
The Honorable Mike Enzi, Ranking Member
Committee on Health, Education, Labor and Pensions
United States Senate
Washington, D.C. 20510

Dear Chairman Harkin and Ranking Member Enzi,

As leading organizations representing millions of Americans with pain and their health professionals and businesses who serve them, we are writing to request that you convene a Committee hearing on the findings and recommendations of the landmark report on pain issued this summer

by the Institute of Medicine of the National Academy of Sciences. The report, *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research*, which was undertaken as a direct result of a bipartisan amendment approved by the HELP Committee, is our best opportunity to date to begin to better tackle a staggering problem that imposes huge and potentially avoidable economic and health care costs on our nation.

The IOM report documents the staggering toll pain takes on individual Americans and their families, our economy, and government budgets and lays out a comprehensive set of recommendations for action. The IOM found that pain is a major public health problem which impacts at least 116 million American adults and costs the nation $560 – $635 billion a year in health care and productivity losses. Much of this cost is born by taxpayers, accounting for 14 percent of all Medicare spending with federal and state government costs totaling $99 billion in 2008.

A hearing by your Committee to hear from the leaders of the Institute of Medicine committee as well as Americans directly impacted by chronic pain and the professionals who care for them would give this important national issue some much deserved attention and provide the Committee with important information on how to both reduce health costs and human suffering through improved pain prevention, care, research and education.

Thank you for your continuing commitment to this major public health issue, and thank you for consideration of our request for this hearing.

Sincerely,

American Pain Foundation (and others)

LICENSURE

Telemedicine Association Calls for Licensure Reform

The American Telemedicine Association (ATA) hosts *Fix Licensure.org*, which advocates for the removal of medical licensure barriers that impede the use of telemedicine. Its goal is "increasing consumer choice, improving safety and cutting costs for patients across America."

It is time for consumers and patients to freely access doctors and other health care professionals.

A call for action at the Website says, in part:

> It is time for consumers and patients to freely access doctors and other health care professionals no matter

where they are located throughout the country. Changes in the way we live, in technology and in new developments I the practice of medicine call for such a change. The old approach, requiring health providers to obtain multiple state licenses and adhere to diverse and sometimes conflicting state medical practice rules, is a barrier to progress, quality, competition and economy. This partitioned approach also presents a concern for patient safety as state-by-state licensing and enforcement inhibits tracking down and disciplining bad doctors in other states.

The ATA says the system affects more than telemedicine, in that some medical practice acts prohibit doctors from issuing prescriptions to their own patients who happen to be out of state. They contend that the current licensure system complicates the ability of healthcare systems to link specialists and clinics into efficient systems of care.

The ATA statement says the organization is open to a discussion of alternative solutions to the problem they describe. Nevertheless, the petition they encourage medical professionals, healthcare consumers and other stakeholders to sign calls upon Congress to "fix medical licensing for 21st century America."

More information is available at: http://www.americantelemed.org/i4a/pages/index.cfm?pageid=1.

Editorial Note: In a related development, nine Rite-Aid drugstores in Michigan are introducing a Webcam-based clinical service through OptumHealth's NowClinic. The service allows patients to consult remotely with a nurse at no charge or with a Michigan-licensed doctor for $45.00.

The Michigan Bureau of Health Professions and its medical board have warned doctors that they may face disciplinary action.

The Michigan Bureau of Health Professions and its medical board have warned doctors that they may face disciplinary action if they prescribe medication after using an Internet questionnaire, or without having an established physician-patient relationship.

Meanwhile in California, on October 7, 2011, Governor Brown signed the Telemedicine Advancement Act of 2011. The act expands eligibility to deliver services via telehealth to all licensed healthcare professionals. The law was praised by the California Telemedicine and eHealth Center, the California State Rural Health Association, the Center for Connected Health Policy, and the California Telehealth Network.

An article by Sara Jackson in the December 9, 2011 online newsletter called Fierce Mobile Healthcare cites a recent article in Hospitals & Health Networks magazine us becoming a necessity for hospitals because of its lower cost and wider reach.

The U.S. Department of Health and Human Services (HHS) has developed new and revised rules that will address privileging, credentialing, and documentation regulations for both in-person and telemedicine visits. The rules are expected to foster telemedicine and save money. The National Rural Health Association (NRHA) has recommended that HHS provide expanded reimbursement for telehealth services for Medicare beneficiaries.

See also this article in Physician News about the complexities of credentialing physicians in telemedicine: http://www.physiciansnews.com/2012/01/30/practical-implications-of-telemedicine-credentialing/.

Minnesota Implements Sunset Statute

The Minnesota legislature adopted Sunset language as part of a budget bill passed on July 21, 2011. The legislation calls for a Sunset Advisory Commission, which includes public members appointed by the Governor. The Commission is charged with holding public hearings on sunset review applications by state agencies.

California Governor Lets Nursing Board Expire

On October 9, 2011, Governor Jerry Brown sent the following message to the California Senate declining to sign the Board of Nursing's sunset extension legislation:

> I am returning Senate Bill 538 without my signature.
>
> The Board of Registered Nursing protects consumers and regulates professional nursing in California and this measure would extent the existence of this longstanding regulatory body until 2016. Unfortunately, extraneous harmful provisions lurk within this otherwise benign sunset extension bill.
>
> These provisions would dramatically expand pension benefits for a select group of the Board's investigators. This makes no sense fiscally and flies in the face of much needed pension reform.
>
> It is unacceptable to jeopardize the extension of this Board's critical consumer protection role by allowing these provisions to be included in this otherwise simple

It is unacceptable to jeopardize the extension of this Board's critical consumer protection role.

sunset extension measure. The Board has existed for 106 years without these enhanced benefits and should continue to do so.

I would as that as soon as it reconvenes, the Legislature send me legislation that both restores the Board of Registered Nursing and restores the provisions of law related to "bureau status" for expired boards. In the interim, I direct my administration to take all actions necessary under the law to protect consumers and nurses alike until the Board is reconstituted in January.

On January 25 2012, the California Healthcare Foundation published an update in its online California Healthline:

Officials Raise Concerns Over Disbanding of Calif. Registered Nurse Board

Concerns are emerging that the disbanding of California's Board of Registered Nursing – which operated for 106 years – could have negative implications for the public, *California Watch* reports (Jewett, *California Watch*, 01/25/12). (See http://californiawatch.org/dailyreport/disbanding-nursing-board-raises-questions-about-public-protection-14609.)

Background

Last fall, Gov. Jerry Brown (D) vetoed a bill (SB 538) that would have extended by four years the board's powers to license or discipline California's 400,000 registered nurses. Those powers expired January 1, 2012. (See http://www.leginfo.ca.gov/pub/11-12/bill/sen/sb_0501-0550/sb_538_bill_20110908_enrolled.html.)

Brown wrote in his veto message that the measure "makes no sense fiscally and flies in the face of much needed pension reform."

The bill also would have made certain investigators for the board eligible for more generous pensions.

Brown wrote in his veto message that the measure "makes no sense fiscally and flies in the face of much needed pension reform" (*California Healthline*, 10/18/11). (See http://gov.ca.gov/docs/SB_538_Veto_Message.pdf and http://www.californiahealthline.org/articles/2011/10/18/brown-calls-for-revised-bill-to-extend-powers-of-nurse-licensing-board.aspx.

Board employees, who investigate 8,000 cases annually, now work as part of the state Department of Consumer Affairs.

Details of the Concerns

Some officials are raising concerns over whether the public is adequately protected from nurses who could require drug treatment or practice limitations.

Jeannine Graves – former board president – said that giving the Department of Consumer Affairs authority over the functions of the board creates a "legal fiction" and does not protect the public or offer due process to nurses.

Richard Rice – a senior adviser to former Gov. Arnold Schwarzenegger (R) – said the disbanding halts the board's work to improve nursing care.

State Response

Russ Heimerich – a spokesperson for the Department of Consumer Affairs – said board employees are continuing their administrative and investigative work.

Melissa Figueroa – a spokesperson for the State and Consumer Services Agency, which oversees the Department of Consumer Affairs – said the changes to the board should not be a concern to the public.

She said the agency is negotiating with the Legislature to quickly reconstitute the board possibly through a trailer bill to state budget legislation (*California Watch*, 01/25/12).

Read more at:
http://www.californiahealthline.org/articles/2012/1/25/officials-raise-concerns-over-disbanding-of-calif-registered-nurse-board.aspx.

Editorial Update: On February15, 2012, Gov. Jerry Brown (D) signed legislation reinstating California's Board of Registered Nursing, which was disbanded earlier this year, the Sacramento Bee's Capitol Alert reports (Siders, "Capitol Alert," Sacramento Bee, 02/14/12). The new bill that Brown signed into law reinstates the board through 2015. It excluded language that would have expanded pension benefits for board investigators ("Capitol Alert,"* Sacramento Bee*, 02/14/12).

Michigan Governor Calls Out Regulation in Health and Wellness Message

It is time to revisit how we regulate health care in Michigan.

Michigan Governor Rick Snyder issued a Special Message on Health and Wellness on September 14, 2011. The concluding section on "Improved Governance" says, "It is time to revisit how we regulate health care in Michigan." To that end, he calls for a "comprehensive review of the Michigan Public Health Code… to determine the need

to amend or rescind existing language or add new language to accommodate the changing health care environment." The message goes on to say:

> Seven years ago we had 17 boards and task forces regulating various health care professions. We now have 25 health profession licensing boards and task forces. In its current form, the Public Health Code does not provide for a sunset review process to determine whether there is value in continuing to regulate a particular health care profession, so the number of boards and regulated professions has continued to grow, unchecked. Likewise, under the current Code, health entities that are credentialed by nationally recognized organizations are required to go through additional regulatory processes by the state. To reduce unnecessary or additional regulation, and cut down on red tape, the Public Health Code could accept national accreditation or certification instead of requiring additional review at the state level.
>
> The Office of Regulatory Reinvention (ORR), created earlier this year, is looking at these various licensed occupations and supporting boards, to make sure that we are not excessively regulating our health occupations and that our regulations are tailored to provide health and safety benefits. Another area of focus is addressing our current and projected health care professional shortages. Physician shortages, for example, are projected to range from 4,400 to 6,000 by the end of the year 2020. It has been estimated that as a result of the ACA, the size of our shortages may quadruple. Should this estimate hold true, Michigan's physician shortage could be anywhere from 16,000 to 24,000 by 2020. This will make it harder to get an appointment with a physician and access to specialized care may become more difficult. We need to find a way to ensure that Michiganders continue to have access to quality care.

The ability to more effectively utilize mid-level practitioners is limited, however, by our current regulatory system.

> Resolving this issue requires that we take a look at how other members of the health care team can partner with the medical community to deliver those services. Understanding the role of physician extenders such as advanced practice nurses and physicians' assistants in the delivery of primary care services is critical to addressing access issues. The ability to more effectively utilize mid-level practitioners is limited, however, by our current regulatory system. Accordingly, I have asked ORR to work closely with the MDCH to develop and implement a strategic plan to address our current and

anticipated shortages in the health care sector and identify the regulatory reform necessary to successfully posture Michigan for future needs.

The complete Message on Health and Wellness can be found at: http://www.michigan.gov/documents/snyder/HealthWellnessSpecialMessage_363226_7.pdf.

QUALITY OF CARE

California Law Strengthens Regulation of Surgical Centers

Legislation passed in California (SB100) and signed by Governor Brown will strengthen regulation of surgical centers. The law was proposed by state Senator Curren Price, Jr. after several deaths occurred at outpatient facilities offering liposuction or Lap-Band procedures.

The legislation expands the authority of private agencies that accredit surgical centers. It also requires the Medical Board of California to post the information on its Web site when a surgical center loses its accreditation. The law prohibits surgical centers that have lost their accreditation to petition a different accrediting agency for authorization to resume business.

The legislation can be found at: http://www.leginfo.ca.gov/pub/11-12/bill/sen/sb_0051-0100/sb_100_bill_20111009_chaptered.pdf.

Medical Error Reporting Improved in Non-Punitive Environment

A research team led by Daniel R. Neuspiel, M.D. found that medical error reporting in an academic pediatric ambulatory practice can be improved by a voluntary, non-punitive reporting system. According to the abstract published online in November 2011:

OBJECTIVE:

Limited information exists about medical errors in ambulatory pediatrics and on effective strategies for improving their reporting. We aimed to implement non-punitive error reporting, describe errors, and use a team-based approach to promote patient safety in an academic pediatric practice.

We aimed to implement non-punitive error reporting, describe errors, and use a team-based approach to promote patient safety in an academic pediatric practice.

PATIENTS AND METHODS:

The setting was an academic general pediatric practice in Charlotte, North Carolina, that has ~26 000 annual visits and primarily serves a diverse, low-income, Medicaid-

insured population. We assembled a multidisciplinary patient safety team to detect and analyze ambulatory medical errors by using a reporter-anonymous non-punitive process. The team used systems analysis and rapid redesign to evaluate each error report and recommend changes to prevent patient harm.

RESULTS:

In 30 months, 216 medical errors were reported, compared with 5 reports in the year before the project. Most reports originated from nurses, physicians, and midlevel providers. The most frequently reported errors were misfiled or erroneously entered patient information (n = 68), laboratory tests delayed or not performed (n = 27), errors in medication prescriptions or dispensing (n = 24), vaccine errors (n = 21), patient not given requested appointment or referral (n = 16), and delay in office care (n = 15), which together comprised 76% of the reports. Many recommended changes were implemented.

CONCLUSIONS:

A voluntary, non-punitive, multidisciplinary team approach was effective in improving error reporting, analyzing reported errors, and implementing interventions with the aim of reducing patient harm in an outpatient pediatric practice.

Find the abstract at: http://www.ncbi.nlm.nih.gov/pubmed/22106082.

Doctor's Suit against Hospital Upheld

In May 2011 a California Court of Appeals upheld a multi-million dollar arbitration award against Cedars-Sinai Medical Center. Brain surgeon Hrayr Shahinian brought the action against the hospital, alleging that it had jeopardized his patients' safety by improperly sterilized and maintained surgical instruments and that hospital staff had engaged in retaliatory measures against him for whistle-blowing, thereby affecting his reputation and income.

At the time of the appeals court ruling, Shahinian was defending against a malpractice suit brought by Cedars-Sinai. The main witness in that suit was the surgeon who replaced Shahinian when he resigned from the hospital.

A U.S. Federal Judge blocked enforcement of a Florida law limiting physicians' ability to question patients about gun ownership and safety practices.

Judge Blocks Enforcement of Law Restricting Doctors' Gun Inquiries

On September 14, 2011, a U.S. Federal Judge blocked enforcement of a Florida law limiting physicians' ability to question patients about gun

ownership and safety practices. The Gun Owners' Privacy Act, signed by Governor Rick Scott in June 2011, was thought to be the first of its kind in the country. It barred doctors from talking about guns unless the topic was "relevant." The penalty could be loss of license and a $10,000 fine.

The judge who enjoined enforcement of the law said it violated doctors' free speech protections and patients' right to receive information about firearm safety. She pointed out that doctors routinely provide information about the prevention of injuries, including firearm safety.

DISCIPLINE

Medical Board No Longer Accepts Anonymous Complaints

Effective September 2011, the Texas Medical Board will no longer accept anonymous complaints, which had been about 4% of the board's complaint load. House Bill 680 requires the board to notify doctors of complaints filed against them by insurers or pharmaceutical companies. Perhaps because of the imbroglio after two nurses from Winkler County Memorial Hospital were fired and charged with felony misuse of official information after filing anonymous complaints against a co-worker physician, legislators did not require the medical board to inform a doctor when another medical professional files a complaint against him or her.

Doctors groups lobbied for this change in the law since 2007, contending that anonymous complaints are subject to abuse. Some alleged that the husband of a former president of the board filed anonymous complaints against the board president's competitors. Opponents of the legislation expressed concern that it would discourage complaints, even though the law allows the board to keep the identity of complainants confidential.

Editorial Note: In another development related to the firing of the two nurses, the attorney who represented the doctor who sued the nurses was found guilty of retaliation and sentenced to four months of jail and ten years of probation. He was also found guilty of misuse of official information and filing charges he knew to be false and was fined $6,000.00.

The attorney who represented the doctor who sued the nurses was found guilty of retaliation and sentenced to four months of jail and ten years of probation.

Medical Board Criticized for Lax Enforcement

An audit of the performance of the Maryland Board of Physicians by the Department of Legislative Services found a worrying backlog of complaints, incomplete recordkeeping, and lack of transparency including failure to comply with open meetings laws. During fiscal year 2011, the board handled more than 1,700 complaints (739 held over from 2010), but ended the year with an 800 case backlog.

The board is facing sunset review in January 2012. According to a report on the audit by Meredith Cohn in the *Baltimore Sun* (November 21, 2011), the auditors expressed doubts that the board would comply with the audit's recommendations, since it had not implemented key recommendations from previous sunset reviews.

Among other things, the auditors recommended withholding funds from the board until it enacts sanctioning guidelines. They also recommend improved recordkeeping and better public information about hearings and disciplinary actions. Board officials pleaded inadequate funding to hire investigators.

Editorial Note: Meanwhile, on October 2, 2011, the U.S. Supreme Court declined to review a Maryland Court of Appeals decision favoring the Maryland State Board of Physicians' discipline of a doctor for failing to comply with a subpoena for records. According to a report in the Federation of State Medical Boards' Fall 2011 Newsline, "The denial of the petition for certiorari ended a 10-year legal battle and alleviated concerns over the interpretation of constitutional privacy rights relative to medical board access to patient records."

Medical Board Praised for Getting Tougher

They credit the Florida Secretary of Health for making enforcement a priority, especially in egregious cases.

Writing in the *Florida Sun-Sentinal* (January 22, 2012), which has published numerous articles about health care licensure in recent years, staff writers Bob LaMendola and Alexia Campbell praise the state's medical board for getting tough on pill mills and sex offenders. They credit the Florida Secretary of Health for making enforcement a priority, especially in egregious cases.

Some observers, the reporters point out, say the board is going after relatively easy cases, but is still too lax on cases of incompetence. Still, in South Florida almost twice as many health care professionals (83) had their licenses revoked in 2010 than in 2009. Another 104 surrendered their licenses rather than face disciplinary action.

Study Analyzes Chance of Being Sued for Malpractice

An article in the *New England Journal of Medicine* (August 18, 2011, vol. 16 # 3) looks at the cumulative risk of being sued for malpractice for 25 medical specialties. The research team was led by Anupam B. Jena, M.D. According to the article's abstract:

> **Background.** Data are lacking on the proportion of physicians who face malpractice claims in a year, the size of those claims, and the cumulative career malpractice risk according to specialty.
>
> **Methods.** We analyzed malpractice data from 1991 through 2005 for all physicians who were covered by a large professional liability insurer with a nationwide client base (40,916 physicians and 233,738 physician-years of coverage). For 25 specialties, we reported the proportion of physicians who had malpractice claims in a year, the proportion of claims leading to an indemnity payment (compensation paid to a plaintiff), and the size of indemnity payments. We estimated the cumulative risk of ever being sued among physicians in high- and low-risk specialties.
>
> **Results.** Each year during the study period, 7.4% of all physicians had a malpractice claim, with 1.6% having a claim leading to a payment (i.e. 78% of all claims did not result in payments to claimants). The proportion of physicians facing a claim each year ranged from 19.1% in neurosurgery, 18.9% in thoracic-cardiovascular surgery, and 15.3% in general surgery to 5.2% in family medicine, 3.1% in pediatrics, and 2.6% in psychiatry. The mean indemnity payment was $274,887, and the median was $111,749. Mean payments ranged from $117,832 for dermatology to $520,923 for pediatrics. It was estimated that by the age of 65 years, 75% of physicians in low-risk specialties had faced a malpractice claim, as compared with 99% of physicians in high-risk specialties.
>
> **Conclusions.** There is substantial variation in the likelihood of malpractice suits and the size of indemnity payments across specialties. The cumulative risk of facing a malpractice claim is high in all specialties, although most claims do not lead to payments to plaintiffs. (Funded by the RAND Institute for Civil Justice and the National Institute on Aging.)

There is substantial variation in the likelihood of malpractice suits and the size of indemnity payments across specialties.

The article can be found at:
http://www.nejm.org/doi/pdf/10.1056/NEJMsa1012370.

IMPAIRED PRACTITIONERS

Board Wants Knowledge of Drug Treatment Participants

According to an article in the *Star Tribune*, officials in Minnesota may revise the policy giving confidentiality protection to participants in the Health Professionals Services Program (HPSP) for chemically dependent practitioners. Under consideration is reporting the names of individuals who return repeatedly to the program.

Staff writer Brad Schrade reported on November 3, 2011, that the Minnesota Board of Nursing has repeatedly expressed frustration that it is not informed of the identities of nurses who cycle through the program multiple times. The situation came to a head with the case of a nurse anesthetist who repeated the program three times without the board's knowledge. Over a period of 15 years, the nurse stole drugs and treated patients while under the influence.

When impairment issues are such that the public is at risk, then the earlier the board knows, the more quickly the board is able to take action.

Board Executive Director Shirley Brekken told the *Star Tribune*, "When impairment issues are such that the public is at risk, then the earlier the board knows, the more quickly the board is able to take action."

Researchers Analyze Physician Recovery and Return to Practice

Amand Buhl, research and communications coordinator for the Washington Physicians Health Program lead a research team that analyzed data from 780 physicians who participated in impaired practitioner programs. Published in the November issue of *Archives of Surgery*, the article abstract reads:

> **Hypothesis:** Rates of relapse, monitoring contract completion, and return to medical practice may differ between surgeons and non-surgeons being monitored for diagnosed substance use disorders.
>
> **Design:** Retrospective 5-year longitudinal cohort study.
>
> **Setting:** A sample of 16 state physician health programs in the United States.
>
> **Participants:** Nine hundred four physicians who underwent treatment for a substance use disorder and were consecutively admitted to 1 of 16 state physician health programs between September 1, 1995, and September 1, 2001. The study analyzed a subset of data comparing 144 surgeons with 636 non-surgeons.

Main Outcome Measures: Rates of continued drug and alcohol misuse (relapse), monitoring contract completion, and return to medical practice at 5 years.

Results: Surgeons were significantly more likely than non-surgeons to enroll in a physician health program because of alcohol-related problems (odds ratio, 1.9; 95% CI, 1.3-2.7; P = .001) and were less likely to enroll because of opioid use (odds ratio, 0.5; 95% CI, 0.3-0.8, P = .002). Surgeons were neither more nor less likely than non-surgeons to have a positive drug test result, complete or fail to complete the monitoring contract, or extend the monitoring period beyond the original 5 years specified in their agreements. Fewer surgeons than non-surgeons were licensed and practicing medicine at the conclusion of the monitoring period, although this difference was not statistically significant.

Surgeons were neither more nor less likely than non-surgeons to have a positive drug test result.

Conclusions: Surgeons in this study had positive outcomes similar to those of non-surgeons. However, further research is necessary to conclude whether surgeons are less likely than their non-surgeon peers to successfully return to medical practice following chemical dependency treatment.

The article can be found at: http://archsurg.ama-assn.org/cgi/search?fulltext=Amanda+Buhl&quicksearch_submit.x=0&quicksearch_submit.y=0.

Federation of State Medical Boards Updates Policy on Physician Impairment

The Federation of State Medical Boards (FSMB) published an Updated Policy on Physician Impairment in the United States in its *Journal of Medical Regulation*, Vol. 97, No. 2, 2011. "Based on current best practices," reads the abstract, "the policy offers a vision for boards and (physician health programs [PHP]) to effectively assist impaired licensees and licensees with potentially impairing illnesses." The policy itself asserts that "PHPs and regulatory agencies agree that public protection is paramount. Safe reintegration of the recovering physician back into the workforce constitutes the ideal scenario. At times, tension may arise among stakeholders regarding an appropriate balance between the goals of protecting the public on the one hand, and assisting the physician in recovery on the other hand."

The policy says it is important to "draw a distinction between 'impairment' and 'illness.' The diagnosis of an illness does not equate with impairment. Addiction, as an example, is a potentially impairing

illness. Impairment is a functional classification. Individuals with an illness may or may not evidence impairment. Typically, addiction that is untreated progresses to impairment over time. Hence, in addressing physician impairment, it makes sense to identify addiction early and offer treatment and recovery prior to the illness becoming impairment."

The policy recommends that PHPs follow guidelines established by the Federation of State Physician Health Programs (www.fsphp.org). "The effectiveness of PHPs," it reads, "are enhanced when they follow principles of accountability, communication and collaboration with their boards and other stakeholders."

The decision of the licensee to seek or accept PHP assistance and guidance should not, in and of itself, be used against the physician in disciplinary matters before the board.

As an illustration of such collaboration, the policy says, "The decision of the licensee to seek or accept PHP assistance and guidance should not, in and of itself, be used against the physician in disciplinary matters before the board. However, PHPs should report substantive non-compliance and make periodic reports of compliance based on ongoing recovery documentation to appropriate individuals, committees, boards or organizations on behalf of compliant licensees in PHP continuing care."

"Ideally," according to the policy, "PHPs services should include the following:

- Wellness programs that address physician health, stress management, burn-out and early detection of 'at-risk behavior.'
- Educational programs on topics, including but not limited to the recognition, evaluation, treatment and continuing care of potentially impairing conditions. These conditions may include, but are not limited to, addiction, psychiatric illness, behavioral problems, physical and cognitive disorders in physicians and other licensed professionals.
- Evidence-based research opportunities when available.
- Resources for the profession, the public and the boards.

The policy goes on to reference FSPHP guidelines PHP programs should follow in such areas as administration and personnel, legislation, support from organized medicine, intervention, evaluation and assessment, treatment, discharge and continuing care, relapse management, confidentiality, reporting statistical data to medical boards, recovery monitoring, record keeping, and accountability. There is a discussion of interface with a medical board, and tracks and criteria for referral to a PHP. Other sections address evaluation and assessment criteria, treatment program criteria, addictive and mental illness discharge planning and continuing care, and relapse management and monitoring.

Interestingly, the policy distinguishes between three levels of relapse: relapse behavior without chemical use, relapse with use outside active medical practice, and relapse with use in the context of medical practice.

The policy concludes by advocating that boards and PHPs develop relationships based on mutual respect and trust.

IN DEPTH

2011 Shimberg Memorial Lecture by Catherine Dower

The following remarks were presented by Shimberg Public Service Award recipient Catherine Dower at CAC's 2011 Annual Meeting.

Thank you. It is a delight to be here. I want to start by saying a few words about Ben Shimberg because I was fortunate enough to have met him.

I remember two stories in particular about Ben.

The first was when we were in New Orleans at the meeting of CLEAR (Conference on Licensure, Enforcement and Regulation) and he took me out to lunch. We had been talking regulation non-stop, all the tensions and debates, and so on. He sat me down and told me about a program in California – called the Health Manpower Pilot Project at the time and now called the Health Workforce Pilot Project. He was excited because this project offered a way to test the expansions of scopes of practice in a controlled setting. California was the only state he knew of with such a project in place. He sent me back to California to track down the project and try to get it replicated in other states.

It ended up becoming a big part of my professional life. It took a lot of work to track the project down, but it was worth my while. It's a fascinating program; it's a jewel of the regulatory system because it gives a waiver to professions wanting to expand their scope to test the expansion in a controlled setting. I have written several reports on this project and spoken about it at national meetings. So, I thank Ben for that lunch because it has affected my professional life in such a strong way.

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It also has a personal side. Last fall my son became very sick with pneumonia. The doctors gave him an antibiotic that gave him a bad reaction, and he stopped breathing. We called an ambulance and on the way to the hospital the EMTs were able to start the nebulizer, which got him through those few minutes. Without the Health Workforce

Pilot Project, which enabled legislative changes for EMTs to expand their scope of practice beyond simply driving an ambulance, the EMTs would not have been able to start the nebulizer in the ambulance.

A second memory of Ben dates to that same CLEAR meeting. We had had a long day and I was beat. I was sitting in the lobby and saw Ben and thought he must also be exhausted. His wife appeared all dressed up. They were going out for a jazz evening. I thought to myself, "This is a balanced life." He works hard, going above and beyond the call of duty on his professional job, but he also has his priorities in place. He was going to enjoy music and food. I have tried to incorporate that into my life. One of the things I do at the Center for the Health Professions is teach leadership programs to healthcare professionals and work/life balance skills. I have used this story often.

He was passionate about regulation and his legacy continues at the Citizen Advocacy Center.

I am touched to be receiving this honor in his name. He was passionate about regulation and his legacy continues at the Citizen Advocacy Center.

When I think of CAC, I think of four things. People call me and ask about practice acts and about disciplinary actions for healthcare professionals. I tell them to call CAC. You guys are amazing. The first thing I think about when I think of CAC is healthcare. There is so much good that we have in the United States in healthcare. There are brilliant, caring, people in the field. I do a lot of work with nurses and I have learned that they are the most trusted profession. I am proud to be an attorney but we rank in trustworthiness right above used car salespeople. I am lucky to be able to work with these more trusted professions who keep me honest and remind me of our potential.

But we also have a lot of problems with healthcare in the country. There are problems with the system and the way care is being delivered. I don't think I am at all unusual. I am not unique in being overbilled or fraudulently billed or waiting too many minutes. I have experienced more critical things. I have been subject to abuse. I still have nightmares about standing in front of the elevator in a medical facility in downtown San Francisco because the dentist I had been seeing tried to attack me after the appointment and after all his staff had left, and I was running down the hall waiting for the elevator.

I've been subject to missteps and misdiagnoses. In my 20s, somebody misread a report and the doctor told me I had 12-15 years to live. I can talk about it now that it's 20 years out. I have been exposed to infections in hospitals, so I was worse when I left than when I entered. This is an ongoing problem. I have been lectured in many healthcare professional's offices about their dissatisfaction with the healthcare system, with HMOs, with Medicare, with reimbursement.

I don't think I am unique. It's not just me. These things have happened to my family and friends. I can look at the research and data out there and see a lot of problems out there. And CAC is doing something about some of these problems and that is exciting because it gives people a voice to bring attention to the problems that we have in this country.

The second thing I think of when I think of CAC is regulation. The public may be unaware, but people like David Swankin and Barbara Safriet can make regulation sexy. They get passionate about it. They bring common sense to the subject. They can feel for a lot of people and that is a hard thing to do. I have full respect for you. CAC has the programs and the faculty to bring the information and support to public members and board staff to help make a difference in terms of regulation.

The third thing I think about in connection with CAC is volunteerism and public service. Someone mentioned earlier today that being a public member is a higher calling. I know that you – especially public members – are the ones reading the bills late at night and learning new languages and acronyms and lingos of the profession. You learn data points and new laws and regulations. It's hard. You meet with and work with people who push you beyond your comfort zone. I know that is difficult and I have tremendous respect for you for doing that. You take the minority or unpopular position many times, and you are often out-voted by the other people on your boards or organizations. And, you come back and make the same point again and sometimes you are able to persuade people to change their votes. I respect and acknowledge you for that. And, I know you all have full lives and that you are doing this often in addition whatever else you have going on. But you are making a difference, and that matters. You are making a tremendous difference in all those problems that exist in healthcare today.

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And you are making a difference because you bring that public voice to the conversation. That's the fourth and perhaps most important aspect of CAC. You listen to the people and speak for them in these health regulatory environments. You are challenging the status quo because it's not good enough for us anymore.

Let me read from an article about the demise of a think tank in California. The author wrote, "The pending demise of a renowned California think tank that serves as a watchdog on campaign finance reform and governance should be more than further proof that independent institutions safeguarding the public interest are becoming an endangered species in a time of growing political partisanship."

You are holding the ground here, and that is really important because there are a lot of pressures and many think tanks that are out to protect the public interest that aren't making it in the current environment. It is critical to keep that alive.

CAC is representing the public voice. It is so important that you give voice to people who aren't able to serve on boards and commissions. Consumers are going to have different demands. I encourage you to encourage others to serve on boards as public members. We need to expand the population of public members. We need to save the public interest organizations.

My daughter is now in fifth grade and she has become cynical all of a sudden. She said to me the other night, "Oh, Mom, you're the best Mommy in the whole world." And then she paused and said, "Well, everybody is annoying, but you are the least annoying person in the world." I came across an assignment she was given to write a couple of paragraphs about her family. Her brother got top billing because he just got a new pet gecko and it is hard to compete with a gecko. I was second. I think she got it. She wrote, "My mom Catherine works at UCSF. She studies different doctor's offices around the U.S. and tries to improve their work and health laws through reports (oral as well as written)."

I would of course add to this. It is not just doctors; it is nurses, physical therapists, and so on. It's not just doctor's offices. It is hospitals and nursing homes, and so on. But the point is that she gets what I am working on, which is really exciting.

A lot of what I am doing these days is tracking what is going on in the health care environment in the United States.

And what we are all working on is exciting. A lot of what I am doing these days is tracking what is going on in the health care environment in the United States, driven by a number of really phenomenal changes: changes in demographics that include a growing, aging, more diverse population; a changing disease burden including acute care and chronic care problems; technological developments, such as electronic health records and telehealth, that are out-pacing care delivery; market-driven changes; changes in consumer needs, awareness, and demands; regulatory and policy changes, including the Affordable Care Act. All of these changes are going to demand reaction and response. And those responses are going to include not only attention to financing and business arrangements, but also to guidelines and disciplinary processes and scopes of practice and continuing professional development aspects of healthcare. Each of those things individually will be necessary, but not sufficient. We have to work on all of them collectively.

I have spent a lot of time on scope of practice. I started doing that a long time ago and I thought that once we started talking about it, people would get it and we could move on. But, that is not the case. It is slow and incremental, but scopes of practice are changing and people are becoming more aware of new practice models. I have been delivering a lot of talks about scope of practice and the thing I want to bring back to you now is that people are beginning to get it. Finally, those of us who have been talking about this for a while are getting through.

I received a call from a sheriff in South Lake Tahoe, who said they had a licensure issue about massage therapists. In California, massage therapists are regulated at the county level. He had been reading our work about scope of practice and wanted to incorporate the principles as they devised their scope of practice for massage therapists.

Another example comes from the IOM's Future of Nursing Committee, where I was a member. I went to a meeting with my paperwork and my case prepared. I knew that I needed to have evidence to make my case. It turns out that I wasn't the one who had to lead that charge. I am bound by a code of confidentiality and silence, but I can say that I wasn't the only one who fully understood what is going on with nurse practitioners and physicians in this country. I'll just say it wasn't the usual suspect you would have expected to advance that case and argue that we need to address scopes of practice and we need to make more sense about the variations from state to state, because these variations are not based on evidence. It's not just nurse practitioners. It is also dental hygienists. There are battles going on over who can whiten teeth. It turns out several professions know how to whiten teeth, but dentistry thought they could reserve that particular service all to themselves. It is very lucrative. They were saying dental hygienists couldn't do it in certain states. It turns out that there is no evidence to that effect.

I was at a state legislative briefing recently where a researcher was able to focus on scope of practice, and I got a call from a state agency head who said it turns out scope of practice variations aren't based on evidence. She had figured this out on her own. So, people are beginning to understand it. We are moving incrementally toward expanded, standardized scopes of practice that are based on evidence. It is exciting that we are getting there slowly but surely.

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Finally, I want to mention that one of my childhood healthcare experiences involved surgery. Before they put me under, they gave me last rites. I still wonder about the wisdom of this. But I think it gave me

a sense of urgency and commitment – that I must live life every day to its fullest and do as much as possible. I am redoubling my efforts at this point and will be taking on additional positions on committees and organizations and try to advance the public interest and to improve health care. It is an exciting time to be a part of it.

There have been a lot of tributes to Steve Jobs during the last week or so, and a friend sent me one of his quotes, which I want to share with you. He said,

> Here's to the crazy ones, the misfits, the rebels, the trouble makers, the round pegs in square holes, the ones who see things differently. They are not fond of rules. We can quote them, disagree with them, glorify or vilify them. But, the only thing you can't do is to ignore them, because they change things. They push the human race forward. And while some may see them as the crazy ones, we see genius, because the ones who are crazy enough to think that they can change the world are the ones who do. (Steve Jobs)

So here's to all of you. Here's to Ben and to CAC. Thank you so much for this honor. Thanks to Ben for being there, and for CAC and congratulations to all of you for being part of such an amazing group. I wish you good luck and hope to see you again soon in the future.

LETTERS

Dear American Pain Foundation Members,

Celebrate with us as the collective efforts of the pain care community succeeded in passing positive legislation in California. Alliances and stakeholders worked together to send letters and emails and make phone calls, which were critical to **AB 507** passing both houses in California. **AB 507**, which was signed by Governor Brown, addresses the removal of obsolete or inconsistent language in California's pain management policy.

These policy changes will significantly address concerns of providers and remove the barriers to timely and appropriate treatment for people with pain.

AB 507 is the next step in improving policy for appropriate treatment of pain because it clarifies circumstances when a pharmacist can be disciplined for dispensing controlled substances, standardizes definitions of pain in the Pain Patient's Bill of Rights to the definition of pain in other code sections, and illustrates how the California attorney general's office may engage pain patients. These policy changes will significantly address concerns of providers and remove the barriers to timely and appropriate treatment for people with pain.

For more information on how this bill improves pain management policy in California, please read the complete text of AB 507 at: http://www.aroundthecapitol.com/billtrack/text.html?bvid=20110AB507 91CHP.

APF thanks so many alliances and individual efforts in the passing of AB 507 – particularly the Northern California Cancer Pain Initiative and the American Cancer Society for their tireless work to get this legislation passed. Additionally, APF thanks its dedicated volunteers – especially the Action Network leaders in California and APF board members who were part of these efforts and testified in front of both the Assembly and House committees who heard this bill. Kudos to all!

Together we CAN make a difference in the lives of people with pain!

Sincerely,

American Pain Foundation