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2004 – Mark Yessian

For tirelessly striving to make health care oversight and regulation more effective, and for personifying the spirit of Ben Shimberg by helping make the system more accountable to the public.

Introductory Remarks

This is a special occasion for me. So I ask for your indulgence for a few moments as I offer some personal comments.

First, I must say that I am honored by Dick Kusserow coming down here to introduce me. For better than a decade, Dick Kusserow was a force as the Inspector General of the U.S. Department of Health and Human Services. The Office of Inspector General is an independent oversight body responsible for protecting the interests of the taxpayers and our program beneficiaries. He was a change agent who drew on the full authority of his office to make a difference. In Teddy Roosevelt fashion, he used it as a bully pulpit.

More personally, Dick created the setting for me to have the most productive years of my career. We came from different backgrounds – he from the world of criminal investigations and me from the more academic environment of political science. But he made the IG's office a big tent and enabled a policy analyst like me to play an important role. Thank you, Dick.

Now let me turn to Ben Shimberg. I knew him for close to 20 years. I was familiar with his work on professional and occupational licensure longer than that. I admired him for his knowledge of the field and for his clear and effective ways of focusing on the key issues. But as I got to know Ben, I admired him even more for his sense of curiosity. He wasn't one of those people who acted like he knew it all. He also wanted to learn more. I can see him in the back of a room taking notes during someone's presentation at a conference. I remember him coming up to me at a conference in Salt Lake City asking to have breakfast with me, asking me questions. I remember him for the way he stayed vital as the years began to catch up with him. He remained curious, current, and involved. It is a great honor for me to give a talk tonight in his memory and to have his wife, Helen, and his daughter, Barbara, in the audience.

Next, I must mention my colleagues at the Citizen Advocacy Center (CAC). There is much about working in a large bureaucracy that eats away at your perspective. It can be deadening. It can sap your initiative and openness to change. As insurance against that I've always sought to associate myself with people outside of the bureaucracy who are full of ideas and committed to change. There has been no better resource for me than the CAC. I've been to nearly all the meetings; spoken at most. This has exposed me to many ideas and good associations, such as the people in this room.

I'm especially indebted to a few people over the years: *Mark Speicher*, who was a most creative director of the Arizona medical board and who is deeply knowledgeable about the world of hospital management; *Art Levin*, who shows that one can be a forceful consumer advocate and also a hard-hitting analyst; *Richard Morrison*, who did pioneering work on the measurement of board activities when he worked for the State of Virginia and who is one of the most perceptive observers of professional licensure I know; *Len Finocchio*, who brings a quick and probing mind to issues concerning health care regulation and who was a central contributor to the issuance of one of the best reports on the topic in recent times – the Pew Health Professions Commission Report entitled

“Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation;” **Ruth Horowitz**, a sociologist who is also the consummate public member with stints in Delaware and now New York and who is soon to present us with a book on boards that will serve as a valuable resource for all of us; **Becky LeBuhn**, who lest any of you are not aware, has been the true force behind CAC and who helps keep us all fired up with her ideas and sense of urgency concerning health care reform and regulation.

And lest I forget, David Swankin, who could have used his deep knowledge of consumer protection laws and issues to have the most lucrative of careers as a litigator, but who chose to work in the nonprofit vineyards leading CAC as a resource to help health oversight boards function more effectively. David, thank you for your constant advice to me on how best to advance the causes we both care so much about. I've learned a lot from you. Not least of all, I've learned a lot from you about what is really meant by the term “friendship.”

I'm almost there. I would like to acknowledge my partner in so much of the good work we have produced over a couple of decades and my good friend, Joyce Greenleaf. Joyce, too, toils within the confines of the bureaucracy and brings great zeal and intellect to her quest to use good analysis to bring truth to power on matters concerning health care oversight.

Finally, to underscore just how personal and special this evening is to me, let me introduce two others who are so important to me and who in their own spheres have been committed public servants: My sister, **Linda Cameron**, who recently retired after serving on the front lines as a kindergarten teacher in Cranston, RI and who is now escaping the Rhode Island winter a bit west of here in Sarasota. And my very special friend, **Jacquelin McBride**, who is an architect and committed neighborhood activist and who, in her position with the Massachusetts Housing Finance Agency, is actively engaged in efforts to provide sound, affordable housing in Massachusetts towns.

My Speech

In my remarks tonight, I will address the duality of roles that licensure boards play: the more obvious and up-front role of protecting the public and the more tacit one of protecting the profession. I'll focus on licensure boards because that is where Ben's work was focused. But I hope that the Quality Improvement Organization board members here will also see relevance to their worlds. There, too, one can see the same kind of tension between the roles of the professional and lay members.

In preparing my remarks, I reviewed much of Ben's work and used it as a trigger to my own thoughts. I drew also on the body of work that we in the Office of Inspector General produced over 20 years. My message is one that will sound critical of boards for not being vigorous enough in their public protection role. So, lest it be seen that I am being too dismissive of the sound intent and good work of so many people who have served as board members, let me note at the outset that over the years I have met hundreds of board members, professional and lay, who are highly committed, who want to do the right thing, and who volunteer their time at much personal cost. I have great respect for them, as I do for many of the executives and staff of these boards who are doing their best to make an imperfect system work as effectively as possible. My critique is more about the systems in which they toil than about the individuals.

And to give you a little more sense of what is coming, let me note that I will find a way to weave into my remarks the insights of two comedians – Rodney Dangerfield and George Carlin and the heroics of the Boston Red Sox. Okay. Let's get down to business.

Protecting the Public or Preserving the Profession?

This is the central question that Ben Shimberg focused on over many decades. And it is the question I would like us to chew on as we digest our fine dinner.

Ben's answer to this question was unequivocal. The mission of boards, he would continually emphasize, is to protect the public, not the profession.

But Ben knew that in practice it wasn't that simple. Since most licensure laws have been established at the urging of the professional groups being regulated, he would say it is only reasonable to ask: "What's in it for them?" While he had great respect for health care professionals, he would say that it is hard to believe that professional groups would engage in the considerable effort to get themselves regulated just for the sake of protecting the public. And he would note that there have been many instances where boards have acted in a way that is clearly contrary to their public protection mission. In practice, he said, board members would too often have the mindset that whatever is good for the profession is good for the public. This reminds those of us who are old enough of the old adage that whatever is good for General Motors is good for the country.

As we look back on the development of professional regulation in this country, this blurring of focus becomes easier to understand. Starting more than 150 years ago, medical boards were established, *not* at the urging of patient advocates, but at the urging of schooled physicians trying to set themselves apart from untrained quacks. They succeeded in convincing state legislatures that these quacks represented sufficient public danger that licensure laws, backed with the police power of the state, should be established to guard the health and safety of the citizenry. And since the legislatures didn't have the expertise to determine the appropriate standards of practice they created boards composed of physicians to carry out the law.

Over the years, this self-regulatory model became the standard, not only for medical boards but also for all other health care boards. And, with some caveats, it still functions as the standard.

In seeking to understand this blurring of roles, it also helps if we remind ourselves that for the professional members of a board, their profession is a very tangible and immediate thing. It represents a specific body of knowledge, one that they draw upon just about every day. It represents a network of collegial interactions built on a set of common expectations and experiences. And it represents their livelihood, a livelihood that can be affected by the actions that boards take or do not take. In contrast, public protection is a more amorphous, nebulous concept. After all, one might say, our profession is geared to helping people; so anything that helps us do that better is helping the public.

Our Entry into this Domain Twenty Years Ago

Our initial focus in the Office of Inspector General was on medical boards. In the early-to-mid 1980's, there were increasing concerns being expressed about how well these boards were doing their job: *concerns* about boards giving licenses to foreign medical graduates who had not been properly trained; *concerns* about licensees being disciplined in one state and then moving their practice to another state in which they were licensed; *concerns* about fraudulent medical credentials.

Given these developments, Dick Kusserow asked us to look into the situation. This took some courage, given that boards are state entities that receive no federal funding and given the sensitivity over any moves toward federal licensing of health care professionals. We justified the federal interest on the basis of the role that the boards play in providing a front line of protection for the beneficiaries

of the Medicare and Medicaid programs. After all, federal law requires that any physicians eligible for reimbursement under those programs must be licensed by the state in which they are practicing.

Our report, issued in 1986, was hard-hitting. At the core, it charged that medical boards were not being sufficiently vigilant in protecting the public. It was particularly critical of the boards' capacity to address cases where the quality of care provided was in question.

The report got a lot of attention. It was front-page news in many papers and widely reported on TV. In short order we were making presentations to the HHS Secretary – then a physician – and to congressional committees. We even published an article on the report in the *Journal of the American Medical Association*.

Emboldened by all this, we proceeded over the next many years to conduct similar reviews of other health care licensure boards and frequent follow up reviews of the medical boards. We also conducted numerous studies of the role of the Peer Review Organizations (PROs), now called Quality Improvement Organizations. The thrust in all of these reports was that the boards and the PROs were falling well short of meeting their public protection responsibilities.

So What Has Happened Over the Past Two Decades?

There are signs of progress. There are more public members on boards. There are more enforcement actions. There is some increase in authorities. In individual states, there have been periods of sustained attention to patient safety, usually in the aftermath of a widely publicized adverse event or a newspaper expose of some kind.

But most boards remain starved for the resources they need to do their job. Most lack sufficient authorities to pursue complicated cases or to assure the continued competence of licensees.

Most still get few referrals from licensees or health care institutions. And on it goes. (If you would like to test how well the current system of licensure is working, ask a health care practitioner in any of your fields if he or she knows of a colleague who has no business practicing and who he or she would never allow to treat a loved one. I do it all the time and am continually amazed by how regularly practitioners acknowledge that they know of such colleagues).

This is of all the more concern because the playing field has changed in the past two decades. Cost pressures, market competition, concerns about liability, the expansion of wonderful but sometimes dangerous medical technologies, and other factors tend to add to the risks that patients face in seeking health care. Health care professionals are themselves getting battered in this health care system and often find themselves hard pressed to deliver the quality service they would like to provide.

So we find that the boards, which a few decades ago were the premier force in health care oversight, have lost ground and in many respects become marginalized. To policy makers, health care professionals, consumer advocates, academics and others, boards get **no respect** – just like the comedian... Rodney Dangerfield. (You remember his lines: “When I was a kid, my yo-yo... it never came back.” “When I was kid, my parents moved a lot, but I always found them.” “When I told my psychiatrist that everyone hates me, he said I was being ridiculous. Everyone hasn't met me yet.”) An apt comparison? You tell me.

- When the Clinton health care reforms were being considered, licensure boards were barely mentioned as a resource to address quality of care issues.
- When the Institute of Medicine came out with a report saying that nearly 100,000 people die each year because of medical errors, one found only the slightest mention of any role boards could play in doing something about this.
- When the Institute of Medicine issued a report setting forth a quality assurance strategy for Medicare beneficiaries, you would not even know that boards had a role to play.
- When the executive director of the Physician Payment Review Commission spoke of trends in medical regulation awhile back, he said that licensure was “playing a relatively smaller role in affecting quality of care.” The insurers, hospitals, and other health care providers, he added, were emerging as the important reviewers of the quality of health care.

So, whether we like it or not, to many knowledgeable observers of the health care scene, the underlying sense is that boards' time has passed. They are products of a bygone era. In our modern age, new mechanisms and more effective ones would have to be found to protect patients and improve the quality of care.

So Why? How did this Happen?

I offer one main answer to this question and two associated ones.

The main answer is that boards have become peripheral to the BIG IDEA that has come to transform health care oversight in the past two decades. That big idea is *continuous quality improvement*. It comes from the theories of W. Edwards Deming and others and from widespread practices in industry that are credited with improving productivity. Its major premises:

- It focuses on the performance of systems, not on the bad apples
- It seeks to improve the overall performance of those systems, not just of the marginal performers.
- It centers around measurement data (metrics) to show the extent of variation on specific practices (for example, aspirin after surgery). It collects the data and then disseminates it with the notion that the outliers will self-correct to the mean.

The earliest expressions in the health care field were Dr. John Weinberg's studies on variations in medical practice – for example, on the rate of tonsillectomies in small Vermont towns.

This philosophy of oversight has been at the very core of how the Joint Commission on Accreditation of Healthcare Organizations oversees hospitals as it carries out its accreditation practices. It is at the core of how the Medicare program views quality of care for Medicare beneficiaries. It is centrally reflected in the Scope of Work of the Quality Improvement Organizations. It is all about the measurement of systems and making everyone better.

Meanwhile, boards lumber on in the *quality assurance* hinterland, focusing on bad apples and on assuring minimum competence, not overall improvement. *No wonder they get no respect!*

But the power of this BIG IDEA is not the only thing that serves to marginalize boards. This idea, focusing on improvement, coincides well with the public and political disdain for regulation, red tape and bureaucracy. After all, what are licensure boards? They are regulatory bodies staffed with

bureaucrats enforcing rules. The big idea also coincides well with professional mind-sets and self-interest. It fits in with their scientific backgrounds, with their proclivity toward data, and with their notions of self-improvement.

Yet another contributing factor is the matter of politics. How many active consumer groups do you find in your states advocating for optometry, occupational therapy, podiatry, acupuncture, or other boards to play a more vigilant role in protecting the public? How many state legislators do you find ready to draw on their political capital to press for more vigorous boards? Not many, I would guess. At the same time, the odds are quite high that anytime a specific professional group is threatened by some board policies or by some efforts to strengthen the board's enforcement efforts, it will make its case strongly to the legislators and it will get a good hearing. The professionals' interest is direct and immediate, often backed by political contributions; the public's interest is more indirect and intangible.

So is it any wonder that in this milieu boards become marginalized? That many professional members can so seamlessly allow themselves to view their board roles as if they were serving on a professional association rather than a governmental regulatory board? The examples of this are abundant. Let me give you a couple of examples from the newsletters of the boards:

- From the incoming president of a medical board: “Whereas in the past, the board was considered to be an adversarial body by its licensees, we have under the leadership (of recent presidents) moved to a more compassionate and egalitarian position which has brought us to enjoy the respect of our licensees.” (What about the public? How about their respect?)
- From the chairman of a dental board: “I have learned that if we, as a profession, do not take control of the political events that affect our profession, then others will advance their agendas which may very well be detrimental to our desired goals and futures. The changing political climate, technical skills, demand for health care services and other changing circumstances in our society demand that we be proactive in our communities, states and at the national level in order to direct the future of dentistry.” (A good rallying talk for the head of a professional association; not appropriate, I would say, for the chairman of a licensure board).

Back to the BIG IDEA that Dominates Health Care Oversight

Lest it appear that I am totally dismissive of the Continuous Quality Improvement (CQI) idea, let me say that I am not. There is much to it that is of value and that warrants application. I've seen the successful use of this approach, especially in the field of dialysis, where some widely supported measures of dialysis outcomes have been developed and are being used to compare the performance of dialysis facilities.

What's important here is to view CQI in perspective. A few years ago, Joyce Greenleaf and I, in an Office of Inspector General report on the oversight of hospitals, argued that it was helpful to consider quality oversight in terms of a continuum. On one side of the continuum you have the Collegial Mode of oversight. This is the CQI side. It is all about educating and elevating. On the other side, you have the Regulatory Mode. It is all about investigating and enforcing. Each mode has distinctive characteristics.

- The collegial mode is cooperative; the regulatory – challenging.
- The collegial fosters improvements; the regulatory enforces minimums.
- The collegial is trusting; the regulatory – skeptical.
- The collegial stresses professional accountability; the regulatory – public accountability.
- The collegial takes a systems focus; the regulatory – an outlier focus.
- The collegial seeks to improve patient outcomes; the regulatory – to minimize preventable harm.

This duality reminds me of the famous comedy routine on the differences between baseball and football by the comedian... George Carlin.

In baseball, the object is to go home: to be safe. In football, the object is for the quarterback, also known as the field general, to be on target with his aerial assault, riddling the defense by hitting his receivers with deadly accuracy in spite of the blitz, even if he has to use the shotgun.

In baseball, you make an error. In football, you receive a penalty.

In baseball, you have the 7th inning stretch. In football, you have the two-minute warning.

In baseball, you wear a cap. (At this point, the speaker puts on a Boston Red Sox cap and gloats over the team's World Series victory the prior night). In football, you wear a helmet.

What I am getting at here is that we need a balance. There is a case for both of these approaches to oversight. But there is not a sufficient basis for putting all our eggs in one basket or the other. That is the judgment reached a few years ago by the National Roundtable for Health Care Quality convened by the Institute of Medicine. In a report offering its conclusions, the Roundtable stated that while the CQI advocates can point to important successes, there are minimal data to document the effectiveness of the approach and “even exemplary practitioners have had difficulty in disseminating its benefits throughout their institutions.”

With respect to the regulatory approach, the Roundtable emphasized that it “is the only mechanism we have to protect the public from egregiously poor providers.” But it then added that it tended to be “inflexible” and poorly suited “to motivate those already performing well to strive for greater achievement.

What we have now is not a properly balanced system. The Quality Improvement Organizations, the federal government's main mechanism for ensuring that professionally recognized standards of health care are provided to Medicare beneficiaries, have always struggled to play a strong regulatory role in regulating patient safety. They do less of it now than ever; they are firmly in the collegial camp. The boards, with statutorily mandated responsibilities to enforce licensure laws, are clearly on the regulatory side of the continuum, but as I have argued are not sufficiently able to hold up their end of the scale.

Viewed in a more positive way, the boards have an opportunity here. They have a market niche they can exploit. They can foster public protection by assuring that minimal standards of practice are being maintained and by holding individual licensees responsible for their practices. These efforts can serve as effective complements to efforts to raise the performance of all licensees and to improve the performance of systems of health care.

But Do the Boards Have the Will to Do It? The Will to Move More Decidedly in the Direction of Public Protection?

The will not only to use their existing authorities and resources to be as effective as possible, but also to bring to others' attention significant constraints they face in doing their job. Boards can be proactive in identifying an agenda for necessary changes and reforms so that they can provide a more important counterpoint to CQI initiatives. If not the boards, who?

And of course this leads us to the role of state legislatures. In a 1987 editorial in the **Journal of the American Medical Association**, written by the leadership of the Federation of State Medical Boards in response to our article that was critical of boards' performance, they offered an assessment that is no less true today than it was then. And that is almost surely applicable to all types of boards:

“The success of boards to improve medical discipline will finally depend, of course, on the funding, staffing, and authority of state boards. These can only come from state legislatures willing to act responsibly... . Those who sit in the legislatures of the various states must recognize that the effective regulation of medical practice is in their hands.

The work of the state medical boards (and I would add nursing, respiratory therapy, psychology and other boards) will always be a direct reflection of the will and purpose of the state legislature.” How true that is!

On this Matter of Will, Public Members of Boards Can Play a Particularly Important Role.

You, as public members, can hone in on this public protection role of boards. You can seek to sharpen the boards' focus on **public** protection – to heighten the boards' accountability to the public, not to the profession.

Of course, all board members – public and professional – have this responsibility to focus on public protection. But you as public members have an advantage here that the professional members do not have. You do not carry the same baggage as professional members. Yes, they have more knowledge of the field being regulated, but their specialized knowledge also serves in various ways to narrow their perspective. In many respects their perspective is limited by their association with the profession. However well-intentioned they may be in protecting the public, they cannot readily leave their professional interests at the door when they enter the boardroom.

Public members can and must take a broader view and serve as constant nudges to see that that broader view informs board deliberations. In fact, it is essential if boards are not to continue to lose credibility. I'm reminded of a comment of Senator Rockefeller speaking sometime back at a Federation of State Medical Board conference. He said: “You have a real problem. You have to show that you can get tough on the outliers in your own profession. Or the pressure for national licensure will come. Maybe not now, but soon.”

So, if you find professional members of your board focused on protecting their profession more than the public – as in the cases I noted – you can call them on it. You don't have to be obnoxious about it. But you can remind them in your own way about the basic mission of the board and how it differs from the mission of a professional association. You can have more influence than you may think by asking hard questions.

- Is there more we can do to address this phenomenon of medical errors that has received so much national attention?
- How can we work more closely and effectively with those who regulate hospitals, nursing homes, and other health care facilities?
- What more can we do to assure the public that once practitioners are licensed they remain competent to practice?
- Are we being sufficiently responsive to consumers when they submit complaints?
- How can we reach out more effectively to those practitioners who are in a danger zone in terms of their competency?
- What can we do to see that practitioners and health care facilities actually send us referrals when they come across practitioners who they know to be dangerous for the public?
- What more can we do to see that board websites are more effective vehicles for informing the public?
- How do we know how good a job our boards are doing? What measures can we use to measure performance over time?
- How can we draw more attention to the barriers that inhibit boards from carrying out their public responsibilities?

These are not mere academic questions for reflection and long-term inquiry. They are vitally important here and now. Many thousands of people depend on boards doing all they can to protect them from incompetent and dangerous practitioners. We have seen too many examples of the harm done to people when boards have not discharged their responsibility adequately.

Your board role is an influential one. You are acting in a governmental capacity, buttressed by the police power of the state. You can make a difference.

In Closing

I started out here by focusing on the work we in the Office of Inspector General have done in addressing professional licensure issues. It is hard to judge what influence we have had. We did at various points in time heighten attention to what is at stake with health care licensure and may have helped trigger some reforms in some states.

In the current policy and political milieu, we, at the federal level, cannot play that same role. That makes it all the more important that you as public members continue to raise questions and press for changes that will enable boards to be more clearly and fully accountable to the public. I know that's what Ben Shimberg would be urging you to do. And it would be a fitting way to honor his life's work.

2005 – Julianne D’Angelo Fellmeth

For her strong leadership at the Center for Public Interest Law, leading to major improvements in the effectiveness and accountability of health regulatory boards not only in California but across the nation.

I am so pleased to be here tonight.

And I am extraordinarily proud and humbled to be given anything that is remotely connected to Ben Shimberg. I had the pleasure of meeting him only a few times – at CAC meetings years ago – but those meetings were a great honor for me because his books and writings and speeches were my best friends as I started my study of occupational licensing agencies 19 years ago.

We are here to carry on the work that he pioneered. His early work serves to guide all of us on the issues we tackle every day – valid and legally defensible licensing standards, performance and ethical standards for regulated professionals, aggressive and accountable enforcement programs that protect the public, and continuing competence throughout the careers of health care professionals.

He is largely why many of you are here. He was concerned about the capture of occupational licensing boards by members of the very profession regulated by that board, and he called for the addition of public members to occupational licensing agencies – but not just any old warm bodies.

He wanted public members who are interested, willing, trained, and supported – people who could counterbalance the views of professional members, question the unwritten rules and traditions that are most in need of questioning, and ensure that regulation is truly in the public interest and not always in the interest of the profession regulated. And CAC is the embodiment of that desire of his.

He was a mentor to me, and his writings should guide you as well. We owe you public members a debt of gratitude, and you owe one to Ben Shimberg because without him you would not be here. You are the theme of this meeting. You – in and of yourselves – are a form of external assessment that is invaluable and important to the proper functioning of health care regulatory boards.

On this very special occasion, I ask you to indulge me for just one additional minute, while I offer thanks to some other important mentors:

David Swankin, Becky LeBuhn, and everyone at CAC: You perform such a tremendous public service by continuing Ben Shimberg's legacy and keeping his dream, his memory, and his work alive. I have attended many CAC meetings and workshops over the years, and have learned so much from them. I especially remember attending a series of meetings that CAC held on impaired health care practitioner programs about six or seven years ago. David and Becky, you will see much of what you taught me at those meetings reflected in my reports on the California Medical Board's diversion program for substance-abusing physicians. Thank you so much for your leadership and your friendship over the years.

Ron Joseph: Thank you so much for taking the time to be here tonight and for your very kind words. In the middle of his 30-year career in public service in California (which is still ongoing, by the way), Ron was the Executive Director of the Medical Board of California for eight years.

– I attended his very first meeting as Executive Director in 1995, and I attended his very last meeting as Executive Director in 2003. Ron is one of the most experienced, knowledgeable, and respected public officials in California. He knew his job, he knew the job of his board members, and he spent a lot of time behind the scenes educating them in their role as government officials with a mandate to protect the public. He understands the virtues of independence. Thank you, Ron, for your support then and now.

I am very pleased that my husband could be here tonight. Professor Bob Fellmeth is the founder and executive director of both the Center for Public Interest Law and the Children's Advocacy Institute at the University of San Diego School of Law. When you honor me, you honor him as well – because without him, there would be no CPIL. You talk about your mentor

– I have learned so much from him over the past two decades.

And we both have an additional mentor in Ralph Nader. Bob was the first Nader's Raider in 1968 in Washington, and worked with Ralph for five of the earliest years of the consumer movement in this country. We are both grateful to Ralph for many things.

I always need to thank Sol and Helen Price. Sol Price founded the Price Club – a little outfit you may have heard of, and he and his wife Helen are legendary philanthropists in San Diego. It was Sol's idea that Bob create the Center for Public Interest Law – to study and monitor and evaluate these invisible creatures called occupational licensing agencies. And it was Sol's endowment in 1990 that will fund CPIL in perpetuity. We – or someone like us – will always be able to educate law students in administrative law, send them to agency meetings, edit their reports about agency activities, and publish them in our *California Regulatory Law Reporter* – all because of the generosity of Sol and Helen Price.

I would also like to acknowledge and thank the University of San Diego and its School of Law. There are not many entities like CPIL. Partly that is because nobody – to my knowledge

– has been stupid enough to try to replicate what we do. But it's also because you won't find many universities or law schools willing to take on an academic center like ours – one that refuses to confine itself to study and writing, one that insists on taking what it has learned and acting on it in public – in the legislature, in the courts, in front of these agencies, in the media, in the outside world. CPIL is an unusual creature, and USD is an unusual university in that it has accepted us, worked with us, and even defended us on several occasions.

And last, I'd like to thank our law student interns – about 1,200 of them over the past 25 years – who have done the real work. They have traveled all over California to attend agency meetings, they have gathered agency documents and questioned agency officials, they have written articles on their agencies for publication in our journal. They have carried out the external assessment that you've been talking about for the past day or two – I just get to take credit for their work.

External Assessment of Regulatory Agency Performance

Your theme at this conference is assessment of regulatory agency performance – that is what I've been doing for the past 19 years. (And yes, I clearly need to get a new life).

I stand before you the epitome of external agency assessment – I've never been on the inside like many of you have. I've never been an agency board member, or a staff member. I have been an outsider for 19 years – monitoring, studying, evaluating, attending meetings, attending sunset hearings, testifying, writing (writing way too much, many California agencies will tell you – Ron Joseph can attest to the fact that I have never in my life been able to say anything in less than 20 pages!).

Why Is External Assessment Important?

First, because regulation that is justified is a very important governmental function. The licensing and regulation of doctors, nurses, pharmacists and other health care professionals, the regulation of lawyers, CPAs, and others with fiduciary duties toward their clients, and the regulation of some structure and design professionals is necessary to prevent irreparable harm to the public – no other mechanism is designed to do that.

We all know from the Harvard Medical School study back in 1990 that the civil tort system is rarely used to address medical negligence. Even when it is used, it is expensive, delayed, inefficient, and ineffective in preventing future harm to future patients – and that's where you come in. Your regulation of these professions is of critical importance.

And that regulation should include all the things Ben Shimberg stood for – fair licensing standards and frequently validated licensing exams, the establishment of practice standards that protect the public and encourage competition among legitimate entrepreneurs, enforcement programs that effectively and decisively excise the incompetent and the impaired from the profession, and – importantly – methods to ensure continuing competence throughout the careers of licensees. So, because justified regulation is important, it is equally important to ascertain whether the regulatory program is accomplishing the reason for its existence.

And it simply makes sense that we don't allow an agency running a justified regulatory program to confine itself to internal self-evaluation. Over the past decade or so, I've done a lot of work on our CPA board in California and one thing I've learned is that auditors can never be put in a position of auditing their own work – that violates the independence doctrine, which is the core of the CPA profession.

It is often necessary to bring in a fresh set of eyes – a set of eyes with a different skill set, background, and perspective. In the California Medical Board Enforcement Monitor project, I just concluded (which I'll talk about later), our team consisted of a public interest lawyer, a 25- year career consumer protection prosecutor, and a management consultant. Those new eyes – separately and collectively – each brought different experience and a different perspective to our in-depth study of the Medical Board's enforcement and diversion programs.

Finally, external review assists in ensuring accountability. Many boards are relatively invisible. Many are controlled by members of the profession they regulate. They are funded by the profession, and the profession expects from them something in return. Many have a poor track record of taking disciplinary action against their own. To put it mildly, they do not always inspire the confidence of the public. Subjecting agencies to meaningful external review ensures accountability to the public – or, at the very least – to the legislative and executive branches whose members we elect.

And external review, while sometimes painful, often yields evidence that is necessary to gain needed resources, or enhanced authority, or new tools that enable you to do the job. The legislature is not necessarily going to believe you – but if you have brought in an outside consultant or auditor who is

independent from you and who produces data and other evidence supporting your need for more resources or authority, the legislature has something to hang its hat on and may just buck that trade association that is lobbying against you.

There are lots of ways to ensure that agencies are externally evaluated – and CPIL has been active in four of them:

First, we've spent 25 years sitting at their board meetings, monitoring their meetings and their decisions, their output, their annual reports, their data, what's on their agenda and – maybe more importantly – what's not. We've covered their decisions and rulemaking and legislation and litigation in a journal that is available not only to them but to the Legislature and the media.

We've spent 25 years studying the structure of these agencies and the statutes that govern how they make decisions. We've also drafted and sponsored legislation that changes their duties and authorities, and requires them to take action in areas they've neglected.

We've also monitored the more general statutes that require them to do what they do in public

– the open meetings act, the public records act, and the administrative procedure act that governs their rulemaking and enforcement proceedings. Frequently, we have sponsored legislation to close loopholes and give teeth to these important statutes.

There are two secret ingredients to any success that we've experienced – and they are not rocket science: First, we simply do not go away. We are always there. We are endowed. And we have a permanent ongoing spigot of law students who are paying tuition money for the privilege of flying to Bakersfield to attend a meeting of the Court Reporters Board. There is no reasonable likelihood that we are going to go away, and these agencies know that. When Charlie Brown of Consumers for Dental Choice needed a co-petitioner in the late 1990's for his petition to our Dental Board, he came to CPIL. He thought the Board might blow him off, thinking that he came from D.C., would soon run out of money, and go back where he came from. When we partnered with him, however, they knew we'd never go away, and they gave him what he wanted. (Little did they know, they had much more to fear from Charlie than from me!)

Our second secret comes from that well-known occupational licensing expert – no, not Ben Shimberg, but Woody Allen: 70% of success in life is showing up. We've been going to these agency meetings for 25 years. I can go, or I can send a student intern. It doesn't matter who goes, or what that person knows: The mere fact that we are there – showing up – has an impact. They know who we are, and they act differently when we are there. Before CPIL was created, there was fairly rampant noncompliance with our open meetings act; after we started attending meetings and questioning their conduct in our journal, they changed their behavior.

I'll give you an example that we chronicled in our journal. We have a board in California that regulates training schools for guide dogs. Back in 1987, a gentleman attended one of this board's meetings because he was interested in something on the agenda. The key vote occurred

– by a show of hands. The gentleman in the audience – who is, of course, blind – asked for a roll call vote so he could ascertain who voted which way. With my student intern sitting there in horror, the Board said no. We wrote about this incident in our journal, and that board has never done that again.

The **second** way in which we, as outsiders, have reviewed these agencies is by undertaking a number of special in-depth studies of their structure and their regulatory programs; we have even gotten outside grants and contracts to conduct these studies.

For example, back in the late 1980's, Bob Fellmeth studied the State Bar's attorney discipline system and succeeded in overhauling the entire disciplinary decision-making process within that system.

Another example: Back in 1986, in a prelude to the recent Medical Board Enforcement Monitor project, we got a three-year grant from a Los Angeles foundation to look at the Medical Board's physician discipline system. We gathered data, studied the system, and conducted interviews for three years; in 1989, we published a report called *Physician Discipline in California: A Code Blue Emergency*. That report led to the enactment of two major bills in 1990 and 1993 – and really set the stage for the continuous review of the Medical Board's enforcement program that has occurred since then.

We have also tried to institutionalize systematic external review of occupational licensing agencies. We were behind the legislation that brought sunrise review to California in 1990, and we were behind the legislation that finally brought sunset review to California in 1995. Since then, we've participated in dozens of sunset review proceedings conducted by the Legislature, and we have filed extensive written testimony on the performance of these agencies that we have gathered through our student monitors.

We have contributed to legislation that has sunsetted or reconstituted agencies, changed their structure, and required them to address abuses they were ignoring. The Board of Landscape Architects, the Board of Fabric Care, the Board of Barbering and Cosmetology, and the Athletic Commission have been sunsetted; the Dental Board and the Optometry Board have been reconstituted. We wrote legislation converting our CPA board to a public member majority – the first and still the only CPA board in the country with a public member majority, and enacting new audit documentation standards that go beyond what the Sarbanes-Oxley Act did at the federal level. Our sunset testimony has contributed to greater public disclosure of information about licensed professionals on agency Web sites – including criminal convictions; civil malpractice judgments, settlements, and arbitration awards; prior disciplinary actions; and hospital peer review actions. Finally, our work has resulted in California's use of the “enforcement monitor” concept at six different agencies – little did we know, but we were creating more work for ourselves because we have ended up participating in three of them.

The **third** way in which we've tried to insert a little “external review” into agency performance is our emphasis on adding more public members to occupational licensing boards, because public members can – in and of themselves – inject an “external” viewpoint independent of the profession into the regulation of that profession.

Before 1970, the composition of most California occupational licensing boards and commissions was 100% licensee – every single board member was a member of the very profession regulated by that board. With the work of Ben Shimberg and the evolution of the Ralph Nader-inspired consumer movement in the late 1960's, our Legislature began to wake up and change the composition of many of these boards to add “public members.”

At first, only a token number of public members were added to these boards – one or two at the most; certainly not enough to make a difference when it came to a vote.

As the years have passed, however, the tables have turned dramatically in California. What used to be a “professional member majority” has given way to a “public member majority” at every occupational licensing board except a few that regulate the health care professions. And even one or two of the health care boards have a public member majority – just this year, our Legislature converted the Acupuncture Board to a public member majority.

This is fairly extraordinary. This has happened just within the past 10 – 12 years. There has really been an epiphany in California.

As California finally commenced the sunset review process in the mid-1990’s, and as the Legislature began to more carefully scrutinize the performance of these industry-dominated occupational licensing boards – and observed firsthand their typical tendencies to enhance the barrier to entry to promote the prestige of the profession or keep out the infidels from other states, adopt standards of practice that benefit the profession or a vocal subset of the profession, and engage in almost no meaningful discipline, the Legislature has slowly but surely reconstituted many of these industry-dominated boards into public member majorities – recognizing the importance of a regulator that is truly independent of the profession, and willing to and capable of making decisions on their merits and in the public interest.

We have strongly supported this conversion – in fact, we believe that no member of any regulatory board should be a member of the trade or profession regulated by that board. No decision-maker on any regulatory board should stand to benefit in any way from his/her own government decision-making.

So we’ve worked hard to place more public members on these boards, and also to place limitations on those who can be appointed as public members. It does no good to kill yourself adding public members to the Medical Board if the Governor can appoint the spouse of a physician as a public member on the Medical Board. It does no good if the Assembly appoints a lawyer or lobbyist for the accounting profession as a public member on the Board of Accountancy. It does no good if the Senate appoints the owner of a barber college as a public member on the Barbering and Cosmetology Board. These people are not independent of the profession they regulate. They have a vested interest in continuing to do things the way they’ve always been done, or in somehow benefitting from their own government decisions. You have to make sure that the public members who are appointed are in fact independent of the regulated profession.

Finally, the last way in which we have participated in the review of agencies is by serving as an external “enforcement monitor.”

As I mentioned earlier, California has created six enforcement monitor projects for various agencies, and CPIL has been involved in three of them – we did a five-year project at the State Bar in the late 1980’s. After a long drought, we finally convinced the Legislature to apply the enforcement monitor concept to occupational licensing boards within our Department of Consumer Affairs – and it has created five enforcement monitor projects since 2001. Between 2001 and 2003, we participated in a two-year project at the Contractors State License Board, and I just finished – yesterday – serving a two-year term as the Medical Board Enforcement Monitor.

The “enforcement monitor” concept is similar to that of an external independent auditor – independent of the board to be studied, and independent of the profession regulated by that board. All of the “enforcement monitor” bills enacted by the California Legislature have some common denominators:

- 1) The Monitor must be delegated significant investigative authority – including express authority to inquire into what is otherwise nonpublic information, such as complaints, investigations, policy and procedure manuals, and impairment program records and files.
- 2) The statute sets forth the monitor's charge in some detail – he or she is charged with conducting an in-depth study of a particular regulatory program, making findings and recommendations, and proposing legislative, regulatory, or administrative changes to improve the efficiency, effectiveness, and quality of the program and its decision-making.
- 3) The statute sets forth how the Monitor will be chosen and by whom – and how the Monitor will be paid. Usually, the Monitor is paid by the agency being monitored.
- 4) When we did the State Bar project, State Bar licensing fees were increased by \$2 per year per attorney – which at that time funded the Discipline Monitor at about \$160,000 per year.
- 5) These projects are usually multi-year projects, and several reports are required during the course of the project – most of which are covered by the media, and which – over time – serve to hold the agency's feet to the fire.
- 6) The statute might require the Monitor to consult with certain people – for example, in the Medical Board monitor project I just finished, I was required to talk to Medical Board and Attorney General staff, the defense bar, physicians and physician organizations, and patient groups.
- 7) Finally, board members and staff are required to cooperate with the monitor – by turning over files, compiling data – including data they don't usually compile, and being interviewed.

In the Medical Board of California (MBC) Enforcement Monitor project, we were required to look not only at the Board's enforcement program, but also its diversion program for substance-abusing physicians – some of whom participate in lieu of enforcement. That made for a very busy two years.

Following a competitive bidding process, I was appointed Enforcement Monitor in October of 2003. Following a year of research, data gathering and analysis, and extensive interviews of over 90 people, we released the Initial Report of the Medical Board Enforcement Program Monitor on November 1, 2004. The Initial Report analyzed in some detail each step of the process; quantified the delay consumed by each step of the process; and made hundreds of findings and 65 specific recommendations for reform. Some of them required legislation, while others could be implemented administratively by MBC. David and Becky were kind enough to print a synopsis of our major findings and recommendations in the CAC Newsletter – so you may be aware of them, but I'll quickly recap them here and then bring you up to date on major California legislation signed last month that has implemented many of our most important recommendations.

The structure of MBC's enforcement program and the process used to handle serious complaints against physicians – which places Medical Board investigators and the Attorney General's specialized prosecutors in separate agencies – is fragmented, inefficient, and outdated.

We currently have the “hand-off method of investigations and prosecutions, and I bet you do too. A Medical Board investigator with little or no legal guidance works up a case and then “hands it off to a prosecutor who has had no involvement in the planning or direction of the investigation and then has no investigative assistance thereafter – a very inefficient disconnect.

Most other similar law enforcement agencies use a “vertical prosecution” model in which investigators and prosecutors work for the same entity; an investigator/prosecutor team is assigned to each case as soon as it warrants formal investigation; and that team handles the case as a team – under the direction of the prosecutor – through its ultimate conclusion.

In the Initial Report, we proposed the transfer of the Medical Board's investigators from the jurisdiction of the politically appointed Board to the Attorney General's Office, and recommended full adoption of the vertical prosecution model for improved enforcement efficiency and effectiveness. And we came very close! We got the essential elements of vertical prosecution written into the law; they are now required for Medical Board complaints that are referred for investigation. Effective January 1, 2006, every MBC complaint referred for investigation must be jointly and simultaneously referred to an investigator and the prosecutor who will draft and file the pleadings and try the case. That team must handle the matter until its ultimate conclusion – no more sequential relearning of factually complex cases by different people as the case moves through the process. Finally, the prosecutor is not only involved in the investigation – but now “directs” the investigation. The investigator works under the prosecutor's direction.

We did not get the transfer that we wanted (the transfer of the Board's investigators into the Attorney General's office), but the Legislature is required to reevaluate that issue in 18 months, and we believe the new teamwork system will have proven its worth by then and that the investigators will be transferred. Vertical prosecution can work where investigators and prosecutors work for different agencies – but it's much easier to implement if they work for the same agency.

The Medical Board had woefully inadequate resources for its important enforcement function. Physicians' license fees had not been increased since January 1994, notwithstanding a 28% increase in the California Consumer Price Index during those eleven years, in addition, the Board was starved for human resources: Since 2001, MBC lost 29 enforcement program positions (a 16.2% reduction) and the Attorney General's Office lost six prosecutors (a 15% reduction) due to the state's 2001-04 hiring freeze – contributing greatly to chronic case processing delays. The Monitor called for an increase in physician licensing fees from \$300 per year to at least \$400 annually. We ended up getting an increase to \$395 per year – a 30% increase in fees. That will enable the Board to reinstate lost enforcement positions, implement vertical prosecution, reinstate work hours for its medical consultant employees who assist with the evaluation of medical records, and adequately staff the Diversion Program.

The Board's case processing times were unacceptably high.

The Medical Board's enforcement process simply takes too long to protect the public. Although state law requires the Board to set a goal of completing an investigation within 180 days from the receipt of the complaint (one year for complex cases), during 2003-04 an average of 340 days elapsed from MBC's receipt of a serious quality of care complaint to the conclusion of the investigation – double the state standard. One reason for this delay is that many physicians refuse to honor lawful MBC requests for patient medical records, and neither MBC investigators nor the Attorney General's prosecutors aggressively enforced existing laws governing medical records procurement. Similar delays plague other steps in the long enforcement process. We recommended that MBC and the Attorney General's Office develop and consistently apply new policies to enforce existing medical records procurement laws and to end other frequent delays in obtaining physician interviews and expert witness testimony.

The Legislature directly addressed the medical records issue by giving the Board new authority to immediately fine physicians who fail to comply with lawful medical records requests without good

cause. This is a big improvement over existing law, which requires the Board – after being ignored – to subpoena the records, then file a motion in superior court to compel compliance with the subpoena, then get a hearing, then ask for sanctions which are usually not granted because the physician turns over the records.

Administratively, MBC and the Attorney General's Office responded to our initial report by cracking down on physicians and health care facilities that do not comply with requests for medical records – they've set stiffer internal deadlines and are now filing more actions to enforce medical records laws, and they have cut medical records procurement time by about 34% in the last year without any new authority or resources.

The enforcement process is routinely delayed and frustrated because expert witness opinions are not exchanged and shared prior to the hearing.

Whereas the Board requires its expert witnesses (physicians) to put their expert opinions in writing and shares them with the other side, defense counsel do not require their medical experts to put their expert opinions in writing and exchange them with MBC or the Attorney General's Office prior to the administrative hearing. This practice stifles the settlement process and often disadvantages the prosecutor at the hearing.

In response, the Legislature enacted a provision that requires any party to a Medical Board disciplinary proceeding who wishes to rely on expert testimony to exchange certain information in writing with counsel for the other party, including a curriculum vitae of the expert; a brief narrative statement of the general substance of the testimony that the expert is expected to give, including any opinion testimony and its basis; and other information. The exchange of this information must occur at least 30 days prior to the commencement of the administrative hearing or as ordered by the administrative law judge.

We think this exchange will increase settlements, avoid costly hearings, and expedite decision-making – which is in the best interests of both the public and the physician.

Many of the Medical Board's most important detection mechanisms are failing it.

Despite an extensive statutory “mandatory reporting scheme” under which hospitals, court clerks, medical malpractice insurance companies, employers of physicians, and physicians themselves are required to report adverse events against physicians, we found that the Medical Board is not receiving information to which it is statutorily entitled about civil judgments, settlements, and arbitration awards against physicians, criminal convictions against physicians, or hospital disciplinary (peer review) actions against physicians as required by law – information that enables MBC to detect possible physician wrongdoing, investigate, and take disciplinary action as appropriate.

Further, physicians themselves routinely conceal information about their own misconduct from the Board through the insertion of so-called “regulatory gag clauses” – provisions that prohibit an injured plaintiff from complaining to or cooperating with the Medical Board – into civil malpractice settlement agreements. We recommended new reporting requirements, the strengthening of existing reporting requirements, and a statutory ban on regulatory gag clauses.

The Legislature responded to several of these concerns:

- It enacted new physician self-reporting requirements concerning civil judgments in any amount and misdemeanor criminal convictions.
- Regarding hospital peer review actions, the bill expedites completion of a comprehensive study of the hospital peer review process to determine whether hospitals are complying with their duty to report adverse peer review actions and if not, why not. You will all be interested in the results of this study, which is to be completed by June 30, 2007.

One thing we didn't get – and we need to get. Current law requires malpractice insurance carriers and employers of physicians to report to MBC whenever they pay out on a claim. However, there is no penalty for filing late, or filing incomplete, or not filing at all – and it is very clear these entities are not reporting everything they are supposed to report. We analyzed the sources of complaints that most commonly lead to disciplinary action – and these sources are among the most reliable. So, our first order of post-Monitor business will be to get some substantial penalties for noncompliance written into these reporting laws for insurance companies and employers of physicians.

Another thing we did not get is a statutory ban on regulatory gag clauses contained in civil settlement agreements. We got a bill through – it was passed by the Legislature, but the Governor vetoed it for the second year in a row, which was very disappointing. We shall return, and we shall prevail.

The Medical Board's public disclosure policy is insufficient.

Although California's public disclosure policy is actually quite progressive compared to those in many other states, we found it to be insufficient. Our laws and regulations do not afford patients the same information that every other stakeholder – including hospitals, insurance companies, and medical boards – routinely gets and relies on in deciding whether to associate with a physician. We got a few improvements, including the required disclosure of misdemeanor criminal convictions that are substantially related to medical practice. And the whole issue of public disclosure that will soon be the subject of (guess what?) some external review! A very respected bipartisan oversight agency called the Little Hoover Commission will look generally at the role of public disclosure in the board's public protection mandate, and specifically at the extent to which the public is adequately informed of the records of physicians through the current statutes and regulations.

Finally, the Board's Diversion Program – charged with monitoring substance-abusing physicians – is significantly flawed.

The Diversion Program's most important monitoring mechanisms – random drug testing, case manager attendance at group meetings of participants, and regular reporting by worksite monitors and treating psychotherapists – are all failing. Further, the Diversion Program – due in part to severe understaffing – has failed to address or even detect these critical failures.

We found that participants in the Program were not drug-tested as often as they should be; they were not terminated from the Program even after repeated violations; and no standards exist to guide the functioning of “worksite monitors” who purportedly oversee Program participants when they practice medicine. We also found that the Program suffers from an absence of enforceable rules or standards to which participants and personnel are consistently held; the Medical Board has failed to adequately supervise the Program; and the Program improperly operates in a vacuum that prevents MBC management from detecting breakdowns in its functioning.

On this issue, the Legislature had a choice: Engage in detailed tinkering with the statutes, or throw it back where it belongs – on the Medical Board's table – for one last chance. The Legislature opted for the latter – and under this new legislation, the California Diversion Program will sunset on July 1, 2008. Prior to that time, MBC has about 18 months to make substantial staffing, operational, and policy changes to improve this program. It will undergo a thorough performance audit by our Auditor General, and the Legislature will have the results of that audit in 2007 when determining whether to extend the 2008 sunset date.

Our hope is that these changes – which have enhanced the Board's resources, structure, and incentives, and which would not have occurred absent external review by an independent monitor – will substantially improve the quality and speed and efficiency of the Board's enforcement program for the benefit of both patients and physicians in California.

What I'm most proud of is the fact that yesterday, after I laid out all of this for our Medical Board (which has been wallowing in this for three years), it agreed that the whole process had been very beneficial and essentially decided to bring in an independent external reviewer every five years – voluntarily.

In closing, no board should ever fear external review – in fact, you should welcome it. There are many ways to ensure meaningful external assessment of regulatory agency performance, and you public members are contributing to that cause both by serving as public members and by being here tonight. You must continue to raise questions and press for changes that will enable your boards to be more accountable and protective of the public interest. Ben Shimberg would want no less.

Thank you for this honor.

2006 – John Rother

For promoting public participation on regulatory and oversight boards as a way to improve health care safety and quality, and for supporting training and networking of public members to enhance their effectiveness.

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

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

It is also fun to be here with Dave and Becky because they do such good work.

Because CAC grew out of something we started at AARP, I think it is appropriate that AARP support it in every way we can. With our volunteers in Virginia, we may be starting another round of innovation in how to be more effective citizen advocates in the cause of health quality.

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

Modern medicine is a more recent profession than many realize.

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

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

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

We have changed a lot in the past 100 years or so. And, now we are going through another kind of revolution in health care. It is a revolution of accountability and transparency, and it may have the

same potential to raise the bar in the same way that requiring doctors to be science-based in their medical training did a century ago.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

“My ultimate protection if something bad happens is to go to court and sue for malpractice.”

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

In other industries the emphasis is on reporting errors right away and looking at system changes to deal with them. As the Institution of Medicine observed, we will never have perfect doctors, so we need systems to catch errors before they occur. An example is electronic prescriptions.

Why, in the twenty-first century, are we still relying on hand-writing? A news report earlier this week said that about 700,000 people are victims each year of mistakes in hospitals due to errors in prescriptions.

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

As much as quality improvement is on our minds, ultimately, we can't have a quality health care system unless we take on other issues, such as universal coverage, affordability, training, and so on.

There is a lot wrong with our health care system and just making sure that the licensure part works is great, but it is not sufficient. Just making sure that doctors are recertified in a comprehensive way every ten years or so is great, but it is not sufficient.

Making sure we publicly report the outcomes of various procedures so we can compare one hospital to another, and maybe one doctor to another, is great, but that is not sufficient either.

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

What are they talking about? They really are talking about the insurance claims system. We have created so many barriers to people doing the right thing that they feel as if they are being smothered. The financial incentives we have created also drive a lot of behaviors. Under fee- for-service, the financial incentive is to do more and more, so that is what we are getting.

We're not necessarily getting better and better. We are not necessarily getting resources directed where they can do the most good.

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

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

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

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

How are we going to change public attitudes? We have already done a lot of research about how to talk to the American people about health care and what people are worried about. You know people are worried about affordability and quality. If we learn how to tap into this anxiety without scaring people, we have a chance to do something way overdue, which is to build a health care system that can reach everyone, that can be based on quality and quality improvement, that can be more

affordable, that can deal with the waste in the system, and that can emphasize prevention and public health.

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

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

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

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

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

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

Thank you very much for this honor.

2007 – Barbara Safriet

For her tireless efforts to remove unjustified barriers-to-practice that limit public access to qualified, safe healthcare professionals.

I am truly honored to be here and to be associated with just about anything that memorializes Ben Shimberg. Over the years, I have used his articles, books, and speeches about the regulation of health care providers. The lessons and truths he identified are just as relevant today as they were when he first published them.

I also thank the CAC and its Board of Directors for their continued efforts to promote and protect the public interest in the health care arena. They do this first by insisting that if the public is to be served, the public ought to participate in the process of drawing up the regulatory framework for the provision of care. Secondly, CAC has continually had as one of its principal goals education of the public about the most important issues and about some of the best practices we can draw on in improving our regulatory framework. They not only have done this consistently, but they have done it in a consistently excellent fashion. For that I am eternally thankful.

I consider this to be the hardest talk I've ever been asked to give – except perhaps for the call I made to my parents after my first term in college to tell them that I had received two Cs and one D minus, and the D minus was really a gift. They were surprised by this news, but nevertheless supportive. My dad's comment during that conversation has been a guiding light for me over the years. He said, "Well, you're still in the game. And, think of it this way: there's lots of room for improvement."

Why, then, is this the second hardest talk I have ever had to give? When Becky pulled me aside at the Federation of State Medical Boards meeting earlier this spring to tell me that the CAC Board of Directors had voted to honor me with the Shimberg Award, I said, "You really can't be serious! If the award were for orneriness and persistence, okay. Ben Shimberg did really important work. You must have made a mistake." From that moment until now, I think there must have been a major typo that is responsible for me having received this award.

The second reason why this is difficult is that David told me I have only thirty minutes. He has told me this every time we talked. He told me in letters. He told me in notes. "You only have thirty minutes, Barbara." I think he really means it.

People who have heard me speak before, or who know me even slightly, know that it takes me thirty minutes to get warmed up! That's because I care about what I do and there is so much to talk about in this area. So, if I don't get to the really important part of the message, blame David. Don't blame me.

The third reason this is quite difficult for me is that I wasn't given any guidance on what I am supposed to talk about. David said, "You can talk about whatever you want – just so long as it is only thirty minutes."

He said he'd help me by sending me transcripts of the previous Shimberg recipients' remarks. But this wasn't helpful at all because their remarks were frighteningly well organized. They were extraordinarily cogent and compelling. And, they were all done in thirty minutes.

So, now you know why this is the second hardest talk I've ever had to give. I don't have ways to express to you how much I feel like an imposter, and I don't have enough time to offer remarks

worthy of my predecessors, so maybe you'll be a little forgiving. And, do remember, on behalf of the CAC Board, that if I was really the intended recipient of this award, their decision was based on previous acts of mine and was made before they heard these remarks. So, don't hold these remarks against them.

Since I learned about this honor in May, I have imagined about fourteen or fifteen different speeches I might deliver. All are still competing with each other in my mind. Let me try to focus on two. The first is about *you* as regulators in the health care arena – board members, board executives, members of other governmental agencies, or national organizations dealing with health policy. The second topic is about *me* as a public member who is interested in health care.

First, there is you. You have unique challenges as licensing board members and other regulators. The good news is that what you do is important. I can't think of a more central aspect of all our lives than health. What you do should have as its goal promoting comfortable, competent, appropriate care that people can afford for themselves and their loved ones. I can't think of a more important public goal, and you are centrally involved.

The bad news is that the cards you have been dealt to utilize in your regulation are a mixed deck. Some cards are missing. Others are marked.

What are some of the things you face in your regulatory efforts? First, the licensees you work with are the product of an uncoordinated educational system. There is too little interdisciplinary education – almost none.

I was heartened to hear yesterday that in some places, physicians and pharmacists will be trained together in some of the basic science courses. How novel! Anatomy is anatomy. I don't care if you are a student nurse, student physician, or student whatever. Anatomy and biology don't change depending on your profession. Yet, we don't educate people together. I think a lot of the inter-discipline fighting and fussing starts right there, because we don't have a coordinated, sensible educational system.

Also, our educational system typically addresses care in the most acute settings, not community settings, not across large populations. We focus on teaching very sophisticated technology, which is great, but most people don't need CAT scanners, or nuclear medicine infusers, or whatever. These things are helpful for some, but when the focus of health care practitioner training is high-tech, high-intervention, acute, episodic care, it is no wonder that we have problems.

Your licensees practice in settings with other types of health care providers who they may be meeting for the first time. They are totally dependent upon working with others, but we don't educate people from the get-go to work with other professions, licensed or unlicensed. We train them up in educational silos and spit them out to situations where they have to be able to practice in teams and recognize, respect, and draw on the skills and learning of others. We just throw them out there and let them flounder.

Secondly, the licensees you work with practice in what we call a "health care delivery system." But, it is not focused on health; it is focused on illness. It is not focused on care; it is focused on cure. And, there is no system to it.

If we talk about "the system" for shorthand's sake, it is fragmented; its dynamic contours reflect an ever-evolving payment structure rather than good, rational organizational principles. If it were

anything other than this, we wouldn't have employment-based health coverage, which is really a silly notion. When is the time you might need health coverage the most? It is when you are not employed. Employment-based health coverage for the majority masks the true cost of health because no one knows exactly how much their health care costs.

Also, your licensees face conflicting expectations and missions. They want to provide the *best* care. Their license says they should be able to provide *good* care. The payers often don't pay for good care; they may pay for *just barely adequate* care. This ongoing tension between the best and the good, combined with the focus on the individual vs. the larger population, is a factor in the lived experiences of health care providers.

Also, your licensees, across the spectrum of health care providers, suffer from a statutory and regulatory framework that is preordained to maximize conflict through scope of practice battles. It is all preordained. This is not to say that health care providers were born with genetic defects making nurse practitioner fight with internists, or certified registered nurse anesthetists fight with the physician anesthetists. (That's what I call them. They call themselves anesthesiologists).

It is not genetic predisposition. It is the legal system because medical practice acts were enacted first in every state and they took up the entire turf. A physician's scope of practice deals with treating by any means – real or imaginary – any disease, defect, deformity, or illness. Never *health*, which is intriguing because one could argue that any physician who practices health promotion or prevention is practicing nursing, not medicine, because the medical practice acts talk only about disease, defect, deformity, illness – real or imagined, physical or mental – and treating it by any means possible, including magnetism. The definition of medicine also includes prescribing any drug or treatment modality, and piercing the tissue of any human.

Well, what's left after all that? When other health care providers came later seeking legal authority for what they do – pharmacists, optometrists, nurses, clinical therapists, physical therapists audiologists, and others – they were perceived by medicine and many other policymakers to be taking away from medicine that which was medicine's. That legal regime persists today as a powerful and historical artifact that you and your licensees have to grapple with every day.

Keep in mind, it is neither necessary nor right to perpetuate this approach of, "We got there first, we took it all, and now that you want something, even though you are capable of doing it, it's ours. You can't have it." That is the wrong mindset.

There is a little brochure on your table which represents a progressive effort by six national organizations representing different providers and regulatory groups to come up with guidelines from a public protection perspective for how to go about addressing scope of practice issues. It is called ***Changes in Healthcare Professions' Scope of Practice: Legislative Considerations***. (Copies are available at: www.ncsbn.org/ScopeofPractice.pdf).

Finally, you have huge challenges in that boards and board members are asked to do more and more each day – investigate more things, verify more things, gather more data, interpret more data, inspect and investigate more people and places, respond to responsible and irresponsible articles in the paper. You are asked to do these things with little staff, less and less money, more and more tasks, and you have to also be mindful of political winds that affect what you do.

When you get frustrated, you need to keep in mind that what you do matters. As you face unique structural, political, cultural challenges, don't forget it is a privilege for you to be in a position to try to improve the health of the people in this country.

Turning to me, what is it about me that might be instructive – other than confirming in your mind that it really was a mistake about who should get this award? What have I learned or experienced that might be helpful in framing some of the issues you have to deal with? All public members, including me, bring with them experiences and perspectives that reflect what really matters from their life on the ground.

I'd like to offer you some snapshots of health care as experienced by me and people close to me over the years. I'm not complaining because, in fact, I and those close to me are among the lucky ones.

First issue: No matter how much regulation you have, it is likely to fail in weeding out providers who have the social skills of a spit bug. Our regulatory scheme is based upon the notion that we are measuring competence. We know we really can't do this, so we require two expensive and arduous hurdles which are proxies for competence – expensive education and passage of a licensure exam. I'm not saying this is bad. But, remember, if we had full faith in either one of these, we would require only one of them. We require both because we don't trust either one.

So, at best, we have two extensive and expensive filters for those we license to be health professionals. But there is no educational system or exam I know that deals with the spit bug problem.

Let me give you two examples of what I mean by a practitioner with the social skills of a spit bug. When my mother was in the hospital twenty years ago, her roommate, Gladys, was recovering all by herself from the amputation of a leg as a result of diabetes. I, along with my mother, father, sister, and family friends tried to pay special attention to Gladys because she had no support system and she had just lost her leg. One afternoon, a young woman physician entered the room, drew back the incredibly ineffective privacy curtain around Gladys' bed and said, "Well, Gladys, I have bad news. We have to take off the other one." And she left. This surgeon may have been fabulously skilled, but to say to a woman who has just lost one leg and whose prognosis is not ducky, "Well, we have to take off the other one" is a spit bug problem that somewhere along the way should impact that person's ability to continue practicing medicine.

A more recent example of the spit bug problem is right here in town. A dear and close friend of mine, after many months of visiting health care providers and sophisticated testing, ended up in a neurologist's office. The neurologist said "Well, you have ALS, or Lou Gehrig's Disease. As you know, that is a death sentence. Here are some pamphlets on ALS. When you have read them, call me if you have any questions."

This neurologist is, by all accounts, one of the best diagnosticians and treating clinicians. But, I can assure you that saying what he said is not the best practice of medicine. I don't consider it even *good* practice of medicine. But it is the sort of thing people encounter every day from some who are licensed to practice. Unfortunately, there is very little one can do to squash spit bugs.

A second issue is clinical skills. Let's return to my mother, aged 89. Some time ago, she went to her cardiologist with both legs very red, very hot to the touch and so swollen that fluid was oozing out of her skin. You don't have to be a rocket scientist to know that something is wrong. Her cardiologist told her to go home and prop up her legs, review her medications and call next week. Two days later,

Mother was in the midst of raging cellulitis and septic shock and ended up in the ER with “do not resuscitate” orders because everyone thought her case was hopeless.

She spent three weeks in intensive care and three more weeks in the hospital as a result of other misadventures like being dropped and having the skin of both legs stripped to the ankle when they picked her up off the floor. But she lived and she laughs about it now.

What kind of diagnostician or health care provider of any sort would say “go home and put your feet up and call me if it doesn’t get better?” Fortunately, through the steadfast good judgment, clinical skills and intervention of her internist, nurses, and physical therapist, my mother got better and is doing quite well, although the experience was so traumatic that she has almost no memory of it.

Let’s talk also about my mother’s experience when she was diagnosed with breast cancer. I’m talking about competence, not spit bug problems. When her surgeon stood on the operating table and put his knee on her sternum in order to do the needle biopsy, this should have been a sign that subtle interventions were not his strength. He went ahead and did the mastectomy and, in the process, he placed two clamps which cut off the major artery and major vein going to and from Mother’s arm. This caused ongoing problems with what I call “elephant arm” and several bouts of blood poisoning or infection because, not only are the lymph nodes gone, but the circulation is impaired. What I remember the most about this experience is what my Mother said after she returned from one of her follow-up visits. She said, “Barbara, I am so blessed and lucky. Yes, I had to have a breast removed, but I don’t have the huge arms I saw on all the other women sitting in the waiting room.” *All* the other women in the waiting room... This is a snapshot of why competence and ability matter.

So, we have looked at one thing regulations can’t deal with – spit bugs – and one they can do something about – ongoing clinical competence in diagnosis and treatment. Let’s look quickly at two or three snapshots from my experience dealing with the other issues that licensing boards spend their time on: problems with sex, drugs and lies.

I don’t have a lot of patience for this. How much education does it take to know that if you are in a position of trust, you don’t have sex with your patients? How much education does it take to know that you should not appropriate drugs and use them for yourself or others in inappropriate ways? How much education does it take to know it is not a good or appropriate thing to lie on reimbursement forms?

I’d like you to focus on competence and quality and clinical skills, but if you poll licensing boards across the country, you will find they spend most of their time on sex, drugs, and lies. Here are just one or two snap shots of my experience with sex, drugs and lies.

My first job out of college was with a local city agency. As a precondition of being formally appointed to the job, I had to have a physical examination by a city physician. It was a 45- minute examination, about 40 minutes of which was spent thoroughly examining and massaging my breasts. I was twenty-one. I had never had a breast exam before. I didn’t say anything.

Once I got home, I thought “there is something weird about this and maybe I should tell someone. But if I do,” I thought, “maybe it will rock the boat and I won’t get the job.” I’ve kicked myself ever since for not saying something. I especially kicked myself when, in the early 1990’s, a young male student came to me to talk about a problem his wife was having in the same city. Twenty-five years after my experience, his wife had been offered a job in city government and was required to take a mandatory

physical examination. Guess what? Most of the examination was spent massaging her breasts. She was traumatized. He was thinking about quitting school to go join her. He came to ask me what to do.

This time we did something. We got her into counseling and I called the City Attorney, the Director of Human Services, and the Board of Medicine to say “twenty-five years of this is enough!” I wonder how many others have been subjected to this kind of “care” and didn’t know to whom to report, that they should report, or even that they could report. Sex, drugs, and lies are a much more common problem than even the disciplinary matrix would indicate.

Let me give you two more snapshots of my lived experience in health care and health law.

Forty-five years ago, working as a candy-striper in a hospital in Paintsville, Kentucky, I was told to help bathe and feed a patient named Mr. Turner. I walked up to his bed and said, “Mr.

Turner, I am Barbara Safriet and I am here to help you in any way I can.” Mr. Turner didn’t respond. I repeated myself. I prodded Mr. Turner.

Mr. Turner was dead.

I went to the nurses’ station and said, “Mr. Turner is dead.” The nurse said, “You can’t say that.” I said, “Well, why in the world not?” She said, “Doctor has not examined Mr. Turner and only Doctor can determine if he is dead.” I said, “Doctor can examine Mr. Turner all he wants, and he can say whatever he wants about Mr. Turner, but I’m here to tell you, he’s dead!”

What I know now that I didn’t know then is that I had waded into the very messy area of scope of practice. If I had said, “I *think* Mr. Turner is dead,” or, “Mr. Turner *appears* to be dead,” that would be a nursing diagnosis and I would have been okay. But I was being introduced to the monopoly on interpreting reality that is called scope of practice. It was a preview of what I have spent about thirty years of my life doing, which is to try to improve and modify and rationalize the legally imposed turf-protection scheme we call scope of practice.

I’ll leave you with one more snapshot – a positive one. It is the collaborative **Legislative Considerations** document I referred to earlier, prepared by representatives of six different regulatory organizations who sat down and asked how, from a public protection and promotion perspective, the regulatory system can identify the things that really should matter in deciding who may determine whether Mr. Turner is dead, appears dead, or might be dead. I didn’t think I’d live long enough to see a document like this one produced through a collaborative effort on the part of six different licensed professions.

The nub of it for me is in this excerpt:

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

What a novel notion! It is not about turf or money or professional prestige. It is about ability and competence to do what the law says you can do.

What do any of these snapshots matter? Well, as a public member of a regulatory board and a person interested in health care regulation, they seem to me to contain the following lessons:

- Regulation is a balancing act. We talk in health care about balancing access, quality and cost. Every decision strikes such a balance.
- Boards and other health regulators need to do the least restrictive thing possible with their regulations, consistent with achieving the goals that have been identified. Sometimes we over-regulate based on inaccurate or incomplete information, poorly formulated goals, or ignorance of the ramifications of our actions on other aspects of health care.
- Things stay in perspective if we remember that it is all about people and their desire to have good health care for themselves and their loved ones at a cost that they and society can afford.

You and other regulators can't do everything to address all the issues. But keep asking "Why?", as we talked about yesterday in the session on root cause analysis. Then, ask "Why not?" We don't need to keep doing everything the same old way. Finally, ask "Who is going to benefit from this action?"

If you ask these three questions, I think you will find, as my father said to me many years ago, "You are still in the game, and there is plenty of room for improvement."

2008 – Polly Johnson

For her leadership in making the North Carolina Board of Nursing an exemplar of health professional regulation and her readiness to embrace new approaches to protecting public health and safety.

I am indeed humbled to be recognized as the 2008 recipient of the Ben Shimberg Public Service Award. It is also quite an honor to be in the same company as the previous recipients of this award. I well remember one of the first times I read an editorial written by Ben in a CLEAR publication in the early 1990's. His comments on the purpose of regulation resonated with me as I struggled with the direction I thought regulation should be going and the realities of where it was at that time. I also remember not only his presence at many of the CAC meetings I attended in the early years of my career in regulation but the genuine respect that he was afforded by all those in his presence. As many will affirm, Ben was not only a wise man for his time but his wisdom and vision for regulation extended well beyond "his time" in our evolving regulatory journey.

Tonight I would like to reflect a bit on our past history of regulation, consider the role of regulation in the present and future context of our fast-paced and interconnected world of the 21st century; and share some of my beliefs about transforming regulation if we want it to remain an important element of consumer protection in this new age. I will assume that all of us here tonight believe there is an important role for health professions regulation. Given the current economic crisis that began in this country and now expands the globe, the role of governmental regulation is a "hot political topic" on the minds of many Americans in these final days before our 2008 state and national elections. During this unsettling economic time, we are being reminded that regulation attempts to provide safeguards when there is potential (or sufficient) risk involved in the services being provided. As defined by *Schmitt and Shimberg in 1996* and quite applicable to both the financial world as well as that of healthcare:

"The Heart of Regulation is to:

- Ensure that the public is protected from unscrupulous, incompetent and unethical practitioners (and practices);
- Offer some assurance that the regulated individual (or organization) is competent to provide certain service in a safe and effective manner; and
- Provide a means by which individuals (or organizations) who fail to comply with the profession's standards can be disciplined, including revocation of their licenses."

As we move forward in regulation, it is helpful to be mindful of our past...

As a quick review of health professions' regulatory history, the "modern" framework for regulating health professions began post-Civil War and continued into the early 20th century at a time of limited transportation when travel across many states as well as state to state took days or even weeks. Few communication networks existed, other than the postal system, the newspaper, other printed information and word of mouth. In rural and small town settings as well as in the neighborhoods of large cities, people tended to know everyone they had to deal with in their everyday lives. Some of us here may even remember when "credit" was granted informally by the merchant according to the customer's character rather than through mega financial institutions. (In fact some of us might like to see the re-emergence of this old model in this current period of financial instability!) But to go back to that earlier time, the automobile, the radio and telephone were having their debut and life was

beginning to change. The concept of regulation evolved with the development of a complex, more urban world where goods and services were provided to the consumer by a variety of, and often unknown individuals.

Our early laws were primarily registration acts that outlined the criteria necessary for one to become registered or be licensed as a health professional; for some this included licensure examinations written by the board members.

Nursing regulation began in 1903 with registration acts; it expanded to include the establishment of statewide standards for education programs between the 1920's – 1940's, moved from permissive to mandatory licensure as well as national licensure examinations by the end of the 1950's. For the next 20 to 30 years we focused on defining, refining and expanding the scope(s) of nursing practice based on educational preparation as well as more clearly articulating both the criteria and processes for disciplinary actions by boards. During these years there was continual advancement in medical knowledge and improvements in the delivery of care but the pace was not such that one was in a constant struggle to keep up with the changes.

But in the 1980's, the delivery of healthcare began to change dramatically with the explosion of information and medical technologies. These new technologies became the underpinnings of the fast-paced world we now live in. By the late 1990's we were finding ourselves challenged with trying to figure out how to provide for consumer protection and patient safety in a new age of “hi tech”, connectivity, real time communication, mobility, consumer choice, distance learning, telehealth, and globalization – to name a few – while still using a regulatory framework that had been created in a very different time in our history.

Over the past 15 years, much attention has been given to consumer protection and patient safety in this country. In 1995 and then again in 1998, the Pew Health Professions Commission issued major reports on policy considerations for reforming Health Care Workforce Regulation to strengthen consumer protection in the 21st century. Our own David Swankin was a member of the Pew Commission Taskforce that challenged us to envision future workforce regulation as “**S.A.F.E.**” – that is:

Sandardized where appropriate; {especially national core licensure standards and scopes of practice};

Accountable to the public; rather than to the profession

Flexible to support optimal access to a safe and competent health care workforce; and

Effective and Efficient in protecting and promoting the public's health, safety, and welfare.”

Next came the hallmark IOM Report “To Err is Human” in late 1999 that not only got the attention of health care practitioners but shocked the public at large about the realities of healthcare in this country. And in 2001, the IOM Committee on the Quality of Health Care in America laid out the fundamental changes needed for a quality health care system in the 21st century in their second report “Crossing the Quality Chasm.” Art Levin, a CAC Board member, was on that committee. Thanks to the work of these and other leaders in healthcare reform, regulatory bodies have been challenged to carefully rethink how we do our business of public protection.

As for my history in regulation, I started my journey toward regulatory excellence when I stepped into the role of Practice Consultant with the North Carolina Board of Nursing in 1988. At a time when the only reasons for Board staff to step into the “real” world of health care were to investigate complaints or review and approve educational programs. I found myself with an exciting, enabling, and proactive opportunity – to help nurses, their coworkers, employers and other regulators better understand the legally-defined scope of nursing practice and the responsibilities that each nurse has for providing safe, effective care in an ever-changing and increasingly complex health care delivery environment. I could only do that work within the context of the various settings in which care was being provided so I made visits to nursing homes, hospitals, ambulatory surgical centers, cardiac cath labs, public schools, prisons, day care centers etc. to better understand the clinical and environmental resources or barriers to the delivery of safe, effective care in the “real” world of healthcare.

Early in my regulatory career, I recognized that such a “consultant” role was not seen as the “norm” for a regulatory body that spent the majority of its resources on licensing and discipline- related activities. But through all my years in regulation, I have been committed to the Board’s being a proactive partner in assuring the delivery of safe patient care for all of our citizens.

Doing the right thing for public protection requires regulatory bodies to partner with professional associations, credentialing bodies, providers, other healthcare related organizations, and the public in new ways if we wish to be a key player in the overall patient safety movement and contribute positively to the health of our citizens in the 21st century.

Gone are the days when meaningful work can be done in organizational silos. The issues are too complex, and no one group has the only “right” answer or “right” set of answers!

As we think about our consumer protection history, most of us would agree that the evolution of regulation has been primarily reactive in nature. We get involved “after something has happened.” This is basically the modus operandi for our society, from families to all sizes of organizations and governing bodies. We generally set down rules or restrictions... ..after something has happened. Discipline is primarily “an after the fact” activity. As part of our public protection responsibilities, regulatory bodies will always be involved in reactive disciplinary activities, to remove individuals from practice who are unfit to provide safe care because of professional misconduct or reckless behavior. However, I believe we must envision our role of assuring the delivery of safe, effective care in a much broader, collaborative and proactive framework. National organizations, including the IOM, NPSF, NQF and IHI are leading the way in cross-system and cross-disciplinary efforts to create safer healthcare delivery systems. CAC’s model for practitioner remediation and practice enhancement put forth in 2000 provided health professions regulatory boards one framework for becoming more collaborative and proactive in our efforts to assure the delivery of safe, effective patient care.

We all know that the number of complaints related to practitioner competence and judgment in the delivery of care, i.e. “practice or quality of care issues not related to personal misconduct”, have significantly increased in the past 15+ years. How should our regulatory bodies manage these complaints in a manner that improves the delivery of safe care to the public? Does taking one out of practice truly enhance safety or is it more of an immediate reaction “to do something”? Are we primarily reacting to a bad or potentially bad outcome and if so – what and how does the practitioner learn from this experience? How does the system improve?

Given my core belief in the inherent dignity and worth of every human being, I believe we as regulatory bodies must take up the challenge to move beyond our reactive system of discipline, which is primarily punitive in nature, and create a proactive framework that focuses on learning and competence enhancement as the route to improving the quality of our outcomes and the delivery of safe, effective healthcare in this country. As we know, “to err is human.” In fact, it is predictable and measurable. But, as humans, we can all learn from our errors in judgment especially when we do that within an environment that supports learning and quality improvement.

Through the development of a strong working relationship with providers and nurse leaders, in 2001, the Board of Nursing was able to successfully launch our version of the CAC-envisioned Practitioner Remediation and Enhancement Partnership (PREP 4 Patient Safety) project – to work with nurses who have provided unsafe care due to deficits in their knowledge, skills and judgments, and with their employers through non-punitive, non-public practice improvement plans that provide the nurse the opportunity to improve his/her competencies while remaining in the workplace. In 2004, we expanded that program to all licensees and work settings based on the very positive feedback of the nursing and healthcare community. Now it is an integral part of the Board’s regulatory activities.

As you have heard today, there is exciting work going on across our country to build a more “Just Culture” within the healthcare delivery environment to help us move from a culture of blame and shame to one of accountability and quality improvement. Building such a culture requires collaboration among providers, health professionals and regulators (of licensees, delivery systems, and reimbursement systems) to analyze the cause (or causes) of adverse events and near misses in a predictable and systematic manner. This framework focuses on the behavioral choice of the practitioner in an attempt to answer the following: Was it simply a human error? If not, what degree of risk-taking occurred and why? Was the risk-taking unintentional or intentional? Did the practitioner deliberately disregard a substantial risk? Once the cause(s) is determined, then accountability (individual and/or system) is assigned and an appropriate action plan implemented to prevent a future occurrence.

You have already heard about the North Carolina Board of Nursing’s partnership with the North Carolina Center for Hospital Quality and Patient Safety to support Just Culture Collaboratives with hospitals in our state. Equally important, the Board of Nursing is using these tools to evaluate complaints received and formulate action plans based on that evaluation. The appropriate action may occur at the employer/system level, in combination with both employer and regulator, or primarily at the regulatory level – particularly if the cause is reckless behavior.

I am proud of the new pathways the North Carolina Board of Nursing has been forging with its internal complaint review and action processes as well as with our provider community in an effort to shift the fabric of our healthcare environment from a no-win culture of blame and shame to the win-win patient safety culture of quality improvement, learning and competence enhancement.

To further this work, The North Carolina Foundation for Nursing Excellence, created by our Board of Nursing in 2002 to enhance the practice of nursing in our state through leadership development, research and demonstration projects, has begun to implement an action plan to create a Just Culture Healthcare Community statewide within the next five years. We have introduced this concept to other health professions regulatory boards as well as to those governmental agencies that license healthcare facilities, and begun working with key members of the long-term care community to implement this learning and accountability model. Our ultimate goal is to build a consistent (and predictable)

approach to evaluating adverse actions at the provider as well as regulatory levels. We must also introduce this concept into health professions education as well as begin educating the public to this new paradigm if we wish to be successful in moving to a more “just” culture of learning, accountability and quality improvement. I am very excited with the commitment of our healthcare leaders in North Carolina to work collaboratively to enhance the delivery of safe care through a system that more objectively evaluates the reasons why a bad outcome occurred and implements a plan to improve the quality of care we provide – both by the individual practitioner as well as at the systems level. Health professions regulators are critical to the success of this paradigm shift!

As I reflect on what regulation looked like in the late 1980’s and where we are today, I believe we have come a long way in better positioning ourselves as key players in the delivery of safe, effective care in the future. Back then, regulation (at least in nursing) focused mainly on licensing, disciplining, approving education programs, monitoring the licensure examination process, and providing guidance related to scope of practice and the performance of new tasks as hi-tech emerged into the healthcare arena. We were basically reactive and opinion-based in many of our decision-making processes and functioned entirely within a single-state regulatory model.

Health professionals now practice in knowledge-driven, hi-tech, hi-touch and interconnected environment that demands competency in the areas of working in interdisciplinary teams to deliver evidence-based care, use of informatics, practicing within a quality improvement framework with the mandate to deliver safe, effective patient-centered care. These core competencies, first laid out by the IOM, must be integrated into educational preparation and ongoing competence development of our current and future healthcare providers. We know that new information expands at such a fast rate that half of what is useful today will be considered obsolete within the next 3 – 5 years. Knowing how to access the most current, applicable and reliable information to support one’s practice is a daily challenge for all health professionals.

Because of the demands of delivering care in this fast-paced, complex healthcare environment, all practitioners must be involved in continuous learning in order to maintain as well as enhance our competencies.

Until recently, the North Carolina Board of Nursing had no requirements for showing evidence of continuing competence at the time of licensure renewal which certainly did not reflect congruence with the ever-changing healthcare environment. After more than 4 years of collaborative work with our professional and public colleagues, the board implemented a reflective practice model for assuring that all licensees engage in learning activities to support either maintenance or enhancement of their competencies.

However, we know this is just the beginning of our journey to better assure the competence of licensees over the lifetime of their practice. The Citizen Advocacy Center and other leaders in consumer protection are challenging licensure bodies to move aggressively toward more objective assessment of competencies on a periodic basis as part of our public protection role. Many national certification, quality and regulatory organizations are working diligently to develop more objective tools for measuring continuing competence. I applaud the commitment of CAC to lead this important regulatory initiative.

As we all know, the world has dramatically shrunk over the past 15 to 20 years (or become flat as Tom Friedman so well describes). We live in a world driven by communication and connectivity –

where geographic lines between states and nations take a backseat to the expanding possibilities of living and learning in a connected as well as virtual world. In healthcare alone, this provides so many new horizons that we struggle daily to keep up with just a few of them! I am particularly excited about the possibilities of simulation to transform learning, enhance critical thinking skills and assess competence/confidence development in a safe environment where we can truly learn without fear of harming patients. Thank goodness we are finally paying attention to how other industries prepare safe practitioners for hi-tech, hi- risk professions!

We all know about our changing demographics in America – about the “browning” and “graying” of America and the shrinking of our American workforce age group. A recent study showed that between 1976 and 2006, the 75 and older age group grew from 9% to 24% of our total population while the 15 to 44-year age group shrunk from 43% to 31% of our population. Our average age in the US grew from 40.7 years in 1976 to 52.5 years in 2006. By 2050, it is projected that 72 of every 100 individuals in the US will be outside the workforce (too young or too old) and there will no longer be one majority ethnic/racial group in this country. This means that 28% of our population will be expected to provide all the services in our country (education, healthcare, transportation, communication, and financial, to name a few). How are leaders in healthcare preparing for these shifts in our population? How do we build a more diverse healthcare workforce and transform a “sick care” insurance system into one that places its priorities on prevention and wellness as well as universal access to services? How do we assure that our future health professionals are adequately prepared to provide care in the new era of the 21st century? Safety – scarcity – technology – mobility – chronicity in a growing aging population – prevention – diversity – access to affordable care... The list is daunting.

Will health professions regulation continue to be a valued contributor to public protection in this rapidly changing world?

As we look at the next 15 to 20-year horizon in relation to globalization and the mobility of a scarce healthcare workforce, I believe we must commit to not only achieving national regulatory standards but also international standards for education, entry-level and continuing competencies for our respective health professions. We are at critical point in time when it is essential that we transform not only health professions education but also how care can be delivered by a shrinking healthcare workforce in order to be better positioned for the future. Transformation in our regulatory standards and processes is also a must to facilitate the delivery of safe, effective care!

If we wish to be strategic partners in the delivery of quality healthcare for all of our citizens in the years ahead, there is no sitting still or being complacent about the “things we do well today.” We must continually ask the key questions – Are we doing the right thing for the future? How are we reshaping our regulatory models that were developed at the late 19th and early 20th century to be meaningful in the very different world of the 21st century? How do we strategically position health professions regulation for the future? James L. Morrison from the World Future Society challenges us to *“Futurize our organizations – that is, create organizations that think in the future tense, and act in the present – as a prerequisite for success in a rapidly changing and uncertain world.”* How many of our Boards truly think in the future tense? How many do strategic planning, set clear goals for what they want to achieve in the next 3 years, the next 5 to 10 years? How much time do you as Board members and staff spend in generative thinking and transformative work?

If health professions regulation is to remain a viable element in the healthcare landscape of the 21st century, we must build more flexible regulatory structures and models that remove unnecessary

barriers to the practice of qualified health professionals in this new age of connectivity, real time global communication, mobility and a shrinking health care workforce. This includes building models to accommodate multistate and, ultimately, cross-country practice. The multistate, mutual recognition model for nursing regulation that has been implemented in 23 states is a working example of a more flexible regulatory model in the US. There are a number of cross-country and regional models being implemented internationally – for example, in Europe, between Australia and New Zealand, and among the Canadian Provinces.

We must also become more flexible by moving beyond “turf battles” related to expanding and overlapping scopes of practice across health professions. Although it may be an “inconvenient or uncomfortable truth” for some health professionals, there is ample scientific evidence that many aspects of health care services can be safely performed by a variety of health care professionals. It is not the job of regulators to protect professions but, as articulated by Ben Shimberg, it is our job to set standards that assure the consumer, to the extent possible, that the regulated individual is competent to provide certain services in a safe and effective manner.

And lastly, we must move beyond making regulatory decisions based primarily on opinion to making decisions based on the best available evidence... This requires us to build a scientific base of regulatory best practices through research that is context-sensitive, policy-relevant and, applicable to all health professions. I would like to especially recognize the NCSBN for supporting the development of this regulatory science through a Regulatory Fellows Program, analysis of member boards’ core regulatory practices and their Center for Regulatory Excellence grant program. I would suggest that now is a great opportunity to partner across health professions to build this scientific base for regulation. Certainly expanding our base of evidence will assist all regulatory boards in improving their processes, customer service and accountability to the public we serve.

Transforming our regulatory structures and practices for the 21st century may seem like an overwhelming challenge to some of you but if you have the commitment to transform your processes, you can do it! You will be amazed with what can be done to build more efficient and effective organizations once you get started on this journey. And thanks to national organizations such as the CAC, and our respective professional associations of regulatory bodies, the foundational work to help us all move into the 21st century has already begun. It is up to us to make it happen!

In a recent conversation I had with David Swankin, he was reflecting on what he has learned over his many years in the area of consumer protection and regulation. He said: *“Good regulatory programs depend on the people who run them; models are important but there is ‘no single best’ one; and, most importantly, public protection requires collaboration among regulators, providers, professional associations, credentialing bodies and consumers.”* I could not have said it better! AND, if Ben Shimberg were here today, I am sure that he would challenge all of us to move beyond the status quo of our 20th century framework and think in the future tense as we continue our journey toward regulatory excellence in this complex world of the 21st century. It is an exciting time to be involved in this important work!

Thank you to the Board of the CAC for honoring me with the Ben Shimberg award. Thanks also to the members and staff of both the National Council of State Boards of Nursing and the North Carolina Board of Nursing who have been “future thinkers” and willing to open up new pathways in our continuing journey to better serve the public. And thanks to you in the audience for being part of this journey. The future of healthcare regulation is in your hands. For the sake of the public, may you manage it wisely!

2009 – Sidney Wolfe

For a lifelong commitment to improving the health and safety of the populace through a wide range of activities designed to make government, health professionals and businesses more accountable.

It is a real honor to receive this award from CAC because you are a group dedicated to patients and consumers. I have a long history of supporting what CAC does. Helping, training, and providing materials for board members – public and licensee – is a wonderful idea and worthy endeavor. You mentioned the Drug Safety and Risk Management Advisory Committee. FDA is another organization with an exemplary program for training consumer representatives on its advisory committees. It is really important to have effective public members on boards, not just a token representation or a quota, but people who have a history of advocacy, who can take on the professionals on the boards and can really make a difference.

I will start my talk by quoting from an Op-ed I wrote in The New York Times in 2003, entitled, A Free Ride for Doctors. The lead sentence refers to malpractice payouts and says, “From 1990 to 2002, just 5 percent of doctors were involved in 54 percent of the payouts – including jury awards and out-of-court settlements.” Later on, I point out that, “Among the 2,774 doctors who had made payments in five or more cases, only 463 – one out of six – had been disciplined.” This is data to which medical boards have access.

The Op-ed goes on to say that you rarely hear doctors say, “We want more doctor discipline.” When is the last time you heard that, except from some of the better members of state medical boards? Generally, organized medicine doesn’t go to the state capitol saying, “We want more doctor discipline.” Organized medicine says, “We want more caps on malpractice payouts.”

Back to the first sentence of the Op-ed: most doctors are practicing good medicine. Most nurses and pharmacists and other practitioners are practicing good medicine. A relatively small number are responsible for a disproportionate amount of the damage done to patients, a small fraction of which result in a malpractice lawsuit. Something like ten percent of cases involving negligence actually winds up in litigation.

So, the difference between states – and this applies also to nurses, pharmacists, and others – is the extent to which a licensing board actually investigates and does something. Health Research Group (HRG) – to the irritation of some people – issues annual rankings of medical boards based on their disciplinary activity. We usually find about a ten-fold difference between the boards that do take the greatest number of serious actions (revocations, suspensions, probation) and the boards that take the fewest actions. Generally, the boards that do more are the same ones year in and year out and the boards that do less are the same ones year in and year out.

HRG contends that more disciplinary activity by licensing boards would result in fewer people being injured or killed, and this would reduce medical malpractice litigation, as well.

Most of you know that, thanks to the American Medical Association, the data in the National Practitioner Data Bank (NPDB) is secret. Neither you nor I can learn the identity of doctors or hospitals from the NPDB. There is, however, a public file that is updated regularly and can be downloaded from the Internet, which is how we are able to acquire some aggregate data.

From the public data, we have learned about a group of licensed physicians who have made between 4 and 30 malpractice payouts each – totally more than \$8 million for each doctor. None of these physicians had been disciplined by any state medical board between September 1, 1990 when the data bank began and the end of December 2004. All of the payouts were made in states where the physicians were licensed and actually practiced.

I encourage public members to take a look at the publicly available data for their states in the NPDB's files. If you did so, this is the kind of information you would find about physicians with large malpractice payouts, but no discipline by their licensing boards, either serious or minor discipline:

- New York Physician #24867 had 8 payouts totaling \$12,712,000 between 1993 and 2002, four times for improperly performed surgeries, twice for unspecified monitoring errors and twice for unspecified surgical errors.
- Connecticut physician #183018 had four malpractice payouts totaling \$12,625,000 between 2002 and 2003, twice for improperly performed surgeries, and once each for a wrong diagnosis and an unspecified surgical error.
- Kansas physician #14052 had fourteen payouts totaling \$10,175,000 between 1991 and 2002, 12 times for delayed performance or improper management of obstetric cases, once for wrong treatment or procedure, and once for an unspecified obstetrics error.
- Pennsylvania physician #33059 had thirty payouts totaling \$10,117,500 between 1993 and 2004, nine for failure to diagnose, five for unspecified errors, three for improper management of obstetrics cases, three for improper performance of surgery, two for failure to treat, one for surgery on the wrong body part, one for failure to obtain consent for surgery, one for delay in treatment of fetal distress, one for failure to treat fetal distress, one for an improperly performed delivery, and one for improper treatment.
- Arizona physician #493 had six payouts totaling \$9,790,000 between 1992 and 2003, twice for improperly performed surgeries, twice for unspecified surgical errors, and once each for a failure to perform surgery and an unspecified treatment error.

Arizona was one of the worst states in our rankings in the late 1990's. Both print and electronic reporters in Phoenix and Tucson starting reading up on the board and asked why doctors with numerous malpractice payments hadn't been disciplined. State legislatures have the power to perform reasonable oversight of licensing boards. If there is inadequate staff, resources, or leadership, legislatures can try to do something about it. Because of the embarrassment heaped on them by reporters, the Arizona legislature began to exercise oversight over the medical board. As a result, they appropriated 24 percent more funds to the board. The executive director was let go. Within three years, the board tripled the rate of serious disciplinary actions. It wasn't because there was an immigration of bad doctors into Arizona. It was because the board was more empowered to do what they are supposed to do. They went from 38th in our ranking to first. They are still among the best five or ten boards.

- Nevada physician #21426 had four payouts totaling \$8,577,500 between 1991 and 2003, twice for delays in diagnosis, once for a failure to diagnose, and once for an unspecified obstetrics error.
- Washington State physician #71555 had four payouts totaling \$8,435,000 between 1995 and 2001, twice for failures to diagnose and twice for delays in surgical performance.

In the other Washington, up until three years ago, there was not one full-time employee at the medical board in Washington, D.C. where I and 4,000 other physicians are licensed and the board didn't do any discipline. The Washington Post did an expose and the City Council held hearings, changed the laws, and increased the appropriation. As a result, D.C. made the greatest improvement of any jurisdiction in our ranking because suddenly, they had the staff to do discipline.

- Illinois physician #127631 had four payouts totaling \$8,285,000 between 1998 and 2003 for improper delivery, failure to treat fetal distress, improper management of an obstetrics case and a delay in diagnosis.
- Tennessee physician #35472 had seventeen payouts totaling \$8,237,500 between 1991 and 2004, 12 times for improper performance of surgery, twice for improper management of surgery, once for equipment problems during surgery, once for failure to obtain consent for surgery and once for an unspecified surgical error.
- Texas physician #37949 settled or lost 13 medical malpractice suits involving improper treatment or improper performance of surgery between 1990 and 1997. Two of the suits involved the same allegation – a foreign body left in the patient during surgery. Damages to this doctor's patients exceeded \$2 million. This doctor has not been disciplined by the authorities in Texas.

These are serious problems. In a conversation earlier this evening, it was pointed out that there are different legal standards in different states. But, the infractions I just told you about are so gross that I don't think a difference in legal standards can begin to explain the inaction of the states. At a minimum, the malpractice data should be a trigger prompting boards to take a closer look at the practice and performance of the physicians involved.

Examples of physicians who committed serious offenses but were inadequately disciplined include:

- An Iowa anesthesiologist who fell asleep during a surgical procedure, inappropriately left the operating room during surgery, and falsified records was merely suspended for one month, fined \$5,000, and placed on five years of probation.
- A Washington doctor who had inappropriate sexual conduct with three patients and attempted to perform a pelvic exam on a patient being treated for upper back pain was merely fined and subjected to restrictions on his license.
- A Maryland doctor who breached the standard of care for the delivery of quality anesthesiology to 21 patients out of 23 cases reviewed by his peers received a reprimand and had restrictions placed on his license.
- A Virginia doctor who twice used HIV-positive semen for artificial insemination was merely fined \$5,000 and reprimanded.
- A South Carolina orthopedic surgeon who was caught using an amputated human foot for crab fishing was merely slapped on the wrist and fined.

Data through 2004 show that only 8.3 percent of doctors who had two or more malpractice payouts were disciplined by any board. Only 1/3 of doctors who had 10 or more payouts were disciplined by any board.

The rate at which doctors with numerous malpractice payouts are disciplined varies enormously from state to state, just as serious disciplinary activity by boards varies from state to state. The range of discipline of doctors with ten or more payouts is between 5 and 54.5 percent.

Just as alarming as the failure of boards to discipline practitioners with numerous malpractice payouts is the fact that only about half the hospitals in the United States have ever reported an adverse action against a doctor to the NPDB.

The problem involves more than data about doctors. And, it's not just the public that can't access practitioner-specific information about practitioners who have been disciplined.

Secrecy at the NPDB prevents non-federal hospitals and nursing homes from learning about the disciplinary records of a variety of practitioners, including nurses, pharmacists and physician assistants. The data bank contains the names of more than 40,000 nurses and 49,000 LPNs who have been sanctioned for health care-related violations, including unsafe practice or substandard care, misconduct or abuse, fraud, deception, misrepresentation, and improper prescribing or dispensing or administering of drugs. There are numerous examples of nurses who move from one hospital to another because the hospital did not know of their disciplinary records.

Section 1921 of the Social Security Act would allow the nation's 5,000 non-federal hospitals and about 700 nursing homes to see data bank records on non-physician health professionals. But this provision of the Social Security Act has never been implemented.

HRG has been pressing for the implementation of Section 1921 for a couple of years. The Bush administration did nothing because the election was pending. HRG wrote to Secretary Sibelius on August 26, 2009 urging her to implement the law and give hospitals and nursing homes access to a comprehensive database so they could learn something about who they are hiring.

We pointed out that keeping data about disciplined nurses and other allied health professionals confidential means that "though they have been disciplined one or more times, many in multiple states, such healthcare workers can get jobs at hospitals or nursing homes because their employers lack awareness of their previous unsatisfactory records."

So, while hospitals have access to data about doctors in the NPDB, this data about other professionals is sitting in the Healthcare Integrity and Protection Data Bank (HIPDB). The remedy is just to transfer this data to the NPDB, thereby allowing hospitals and nursing homes to access it. In October, Secretary Sibelius wrote to us saying they have sent a final rule to OMB and expect implementation of Section 1921 in the near future.

I conclude by quoting from an editorial that appeared in the Journal of the American Medical Association in 1987:

The success of boards to improve medical discipline will finally depend, of course, on the funding, staffing, and authority of state boards. These can only come from state legislatures willing to act

responsibly... Those who sit in the legislatures of the various states must recognize that the effective regulation of medical practice is in their hands. (JAMA, February 13, Volume 257 pp. 828-9).

A final word to this audience: I think part of every board member's responsibility – but more likely to be something the public members are going to do – is to make sure that the appropriate legislative committees are interested and informed so they can take legislative action to help make the boards more effective and make your job as a public members better and more satisfying.

2010 – Art Levin

For his lifetime of achievement in consumer advocacy, and for setting the standard for effective consumer representation on healthcare oversight bodies.

A few weeks ago, while reviewing materials for this meeting, I noticed for the first time that I was billed as giving a “lecture”; something I frankly have no intention of doing. My “no lecture” stance flows from personal experience; one being that my own education consisted primarily of Socratic method rather than the lecture hall; and second and more to the point, that I, like everyone else in this room, have been lectured to nonstop over the last several weeks.

This onslaught, yea tsunami, of continuous political admonishment reached a level of pain usually associated with needing a root canal. So I, for one, do not want to re-awaken those frayed nerve endings.

Now I have not read the fine print of the award text – but I hope that this wonderful Ben Shimberg honor doesn’t come with a legally binding requirement to lecture – or risk a demand to surrender the award. And so, Dave, whatever the legal status, I am not giving the Shimberg award back. End of story.

I propose to spend the rest of my time talking about several concerns that in one way or another bubble up from my personal experience over three plus decades of work as an advocate, as an itinerant public member of varied oversight and policy bodies and as a generalist policy wonk, without portfolio. I believe there is a general lack of appreciation of the relevance of continued competency and scope of practice, to the larger discussions about health care transformation.

Taken out of context, these two concerns seem somewhat rarified – and perhaps of interest to only a few. Continued competency appears to some to be the rightful purview of the health professions themselves and scope of practice likewise, but the latter has the added complication of interference from state policy makers and professional guild lobbyists added for good measure. I would propose that the success or failure of our journey to transform/reform how health care is delivered, or better put, how health care is experienced by patients and their families, is to no small degree dependent on recognizing the critical need to resolve continued lack of progress in these two areas of concern.

Last year marked the 10th anniversary of the Institute of Medicine’s report on medical mistakes, *To Err is Human*. The report had unusually strong words for its audience. In addressing the alarming human and economic costs associated with an error-ridden delivery system, the report warned, **“The status quo is not acceptable and cannot be tolerated any longer. Despite the cost pressures, liability constraints, resistance to change and other seemingly insurmountable barriers, it is simply not acceptable for patients to be harmed by the same health care system that is supposed to offer healing and comfort.”**

This was a powerful admonition, a lecture if you will, on the immorality of allowing preventable medical harm to continue.

Many of us in the advocacy community noted the 10th anniversary of the errors report by pointing out that, despite the considerable public attention and the arguably impressive effort being invested by providers to make care safer, we do not know whether a hospitalized patient is any less likely to be injured than she or he was ten years ago.

This year marks the 10th anniversary of the other shoe dropped by the IOM Committee on the Quality of Health Care in America – *Crossing the Quality Chasm, A New Health System for the 21st Century*. Arguably the most important report to ever come out of the IOM, it put forward a bold vision for a complete system re-design noting that, **“The American health care delivery system is in need of fundamental change. Many patients, doctors, nurses and health care leaders are concerned that the care delivered is not, essentially, the care we should receive...Health care has safety and quality problems because it relies on outmoded systems of work. Poor designs set the workforce up to fail, regardless of how hard they try. If we want safer, higher-quality care, we need to have redesigned systems of care...”** (I had the privilege of serving as the “public” member of that committee and will describe that experience later).

These two reports offered up a number of recommendations, some of which were more eagerly embraced by the health care provider and professional community than others to put it kindly. And some recommendations simply fell off the radar screen in short order – in my opinion because they were seen as potentially alienating the health care professional communities.

For example, the Committee’s first report, *To Err is Human*, made a strong recommendation related to a topic I suspect is near and dear to the hearts and minds of many of those in this room – the need for routine assessment of continuing competence.

Recommendation 7.2 Performance standards and expectations for health professionals should focus greater attention on patient safety.

Health professional licensing bodies should:

- 1) Implement periodic reexaminations and relicensing of doctors, nurses and other key providers, based on both competence and knowledge of safety practices; and
- 2) Work with certifying and credentialing organizations to develop more effective methods to identify unsafe providers and take action.

This recommendation quickly disappeared from the radar screen and only a few individuals or organizations, Citizens Advocacy Center among them, subsequently appeared very interested in launching a search and rescue mission.

Crossing the Quality Chasm also contained a recommendation that resonates with the focus of this meeting. Recommendation 12 suggests the need for **“restructuring clinical education to be consistent with the principles of the 21st century health system.”** The report noted that a major challenge exists in transitioning the health care system of the 21st century envisioned in the Chasm report – one that is safe, effective, patient-centered, timely, efficient and equitable. That challenge is the preparation of the workforce to acquire new skills and adapt to new ways of relating to patients and to each other.

Specifically, the Chasm report cites the need to:

- 1) Redesign the way health care professionals are trained to emphasize the aims of evidence based practice and multi-disciplinary approaches.
- 2) Modify the ways in which professionals are regulated to facilitate the changes in care delivery. “Scope of practice acts and other workforce regulations need to allow for innovation in the use of all kinds of clinicians to meet patient’s needs in the most effective and efficient ways possible.”

These recommendations undergird a strong case for why assuring and assessing the continued competency of health care professionals and removing the artificial barriers to teamwork inherent in scope of practice laws deserve more breadth and depth of attention than it ordinarily gets in the policy arena. Let me embellish a bit. The processes by which we educate, train, license and provide oversight for the health professions is simply put, stuck in the 19th century or to be more than generous, in the early part of the 20th. It harkens to a time when doctors had little in their black bag but reassurance and a few nostrums (if you were lucky they were opiate based) of doubtful efficacy; when nurses attended to the personal needs of patients and comforted them; pharmacists were hard at work mortaring and pestling noxious ointments that stained clothing permanently and a whole lot of today’s specialized health professions did not even exist. What exists today is clearly unequal to the task in a 21st century health care environment featuring ever increasing professional specialization; the constant diffusion of new, complex technologies whose benefits may be great but whose toxicity is as well; a body of evidence of varying robustness and varying and contradictory conclusions that seems to grow exponentially by the minute; and the complexity of caring for an aging population that is kept mostly vertical by what the great biologist, physician and educator Lewis Thomas long ago described as “half way technology” that may add to life span but not the quality of life.

This disconnect between what professionals may end up actually doing in their everyday clinical practice and the relevance of their earlier education and training, seems to me to be obvious, yet health professionals appear to be held hostage by their own hidebound traditions and financial turf fears, and so are mostly appear oblivious to the compelling need for a complete workforce education and training reboot.

The Chasm Report points out that the current systems designed to deal with competency which include the mainstays of licensure, credentialing and privileging, do not generally employ real time testing to assure that skills are current for what that individual professional actually does in their practice and have not deteriorated. The industry comparator is the rigorous and never- ending demonstration of current and relevant competencies that airline flight crews must demonstrate to fly commercial airliners.

In describing the growing use of and interest in the value of multidisciplinary teams, the Chasm report pointed out that such effective teams must be created and maintained. “Yet members of teams are typically trained in separate disciplines and educational programs, leaving them unprepared to enter practice in complex collaborative settings.” Once again the comparator is the airline industry, with its emphasis on crew resource management. At meeting after meeting, multidisciplinary team approaches to safety and quality so that patient experience is improved are described as contributing to the success of the improvement enterprise. But little if any progress has been made in reforming professional education and training to better support the aim – at least that I am aware of.

Some might wonder why I have spent so much time citing two IOM reports that are 10 and 11 years old. I do so because I believe they serve to highlight how critically important the issues of health professional competency and scope of practice are to the goal of care transformation and system reform.

The goals of reform have recently been re-articulated into a kind of insider shorthand – known as “the Triple Aims.” First conceived by Don Berwick and his colleagues at the Institute for Health Care Improvement, they are rapidly being taken up by others – and of course with Berwick now at CMS we can assume they will help guide that agency’s future work as well.

The triple aims are

- 1) to improve the health of the population;
- 2) to enhance the patient experience of care (including quality, access and reliability); and
- 3) to reduce, or at least control, the per capita cost of care.

Assuring the competency of health care professionals to do what it is they do in their encounters with patients – and allowing a more professionally diverse reconfiguration of the professional workforce that will respect skill and knowledge over credentials, seems to this observer concordant with the triple aims. Reducing preventable harm and maximizing the quality of outcomes certainly can contribute to the health of the population, make for a better patient experience and can reduce costs.

Let me switch subjects now and talk a bit about my own experiences as a “public member” over the years and what I view as the failure to provide the kind of support for public members needed to optimize their effectiveness.

To my mind, public membership is first about transparency, especially in the context of state boards that license and provides oversight of the health professions. Having “outsiders” to at least bear witness, if not actively shape, to what essentially is an “insider” process is important for a number of reasons. I think many of us believe that public members can change the group dynamic simply by their presence in ways that can enhance public safety. Their presence can help hold state oversight agencies accountable for the quality of the work that they do. And most important, public members can bring what is more often than not the missing perspective of the subject of all health care interventions, that of patients, to the table.

Over the years, advocates and advocacy organizations such as CAC have been effective in lobbying for greater public participation in the health professional oversight process. States may vary as to the robustness of the mandate, whether it concerns aggregate numbers, percentages, definitions of public member eligibility and levels of governance, but few have not made some concession of public participation. Yet, I would respectfully suggest that we are far from having realized the intended and unique potential contributions of public members. That is in large part because of the practical reality that they are mostly abandoned after their appointment. What do I mean by abandoned? Well they receive little or no training and mentoring. They are expected to effortlessly glide into their seat at the table and magically understand the rules of the game.

They are never evaluated as to the quality of their participation. They are often at a disadvantage as to their subject matter experience and education and if they lose their way because of that reality, are at great risk of being co-opted by the insider process.

So I wonder what would be a realistic expectation of the potential contributions of public members, given how little we appear willing to invest in their support. While I have not suspended my long running belief in the potential benefits of having outsiders at the insider's table – I worry that we run the risk being falsely assured that our interests are being adequately protected when they are not.

Earlier I described myself as an itinerant public member. Among my forays into the world of “public membership” was my service as the consumer representative on what was a brand new FDA Advisory Committee (Drug Safety and Risk Management or DSaRM) in 2003 for a four- year term and as an “invited” expert on safety and risk management at meetings both before and after my term of service on DSaRM.

FDA statute and regulation require that there be a consumer representative member serving on each drug and device advisory committee and present at every meeting. While all advisory committee members have their travel and lodging paid for – and all receive the same modest per diem – that is the where the support stops. The agency has no program to nurture consumer reps, or for that matter new scientific and clinician members as they begin their service. Now for many of the latter, an FDA advisory committee meeting is familiar territory. But FDA policy is to limit consumer representatives to one full term on a committee, although some do come around again to serve on another committee. This means the overwhelming majority of public members are new to their role and most have never even observed a meeting before.

With the average committee meeting only once or twice a year, there is not much on the job learning opportunity either.

So picture this: You are the new public member on an FDA advisory committee and you walk into a hotel ballroom in Bethesda, or Rockville, or Gaithersburg to find an audience which can number in the hundreds, the sponsor's clique of elegantly groomed women and men, TV cameras, reporters, and a group of experts who know each other professionally, even if it's their first experience on the committee. You likely know no one and no one knows you.

I frankly am surprised that some public member newbies just don't turn around and leave – it can be that overwhelming. Now approximately three weeks before the meeting you received a FedEx package containing a CD of 300 – 400 pages of background material, but no coaching in how to approach this overwhelming task. I was lucky; I had colleagues who clued me in as to what I needed to pay attention to in the briefing materials and what I could let slide. Then the meeting begins, the chair asks everyone around the table to identify themselves, and you settle in to listen to hours of complex presentations with lots of complex tables and graphs and references to Kaplan-Meier survival curves. Well, it's no wonder that the majority of consumer reps remain silent unless specifically asked to comment and rarely, if ever, offer a dissenting opinion.

Needless to say, this does not describe my behavior as a consumer rep. In fact, I came to refer to myself as “Dr. No” because on numerous occasions I was the lone dissenting voice when a panel voted to leave a drug on the market despite serious safety concerns. But I would be dishonest if I did not admit that even for me, it was often daunting to be in such a hothouse atmosphere and to be willing to go on record as opposing the majority opinion.

In all my years of experience with the FDA advisory committee process, there were exactly two in-person “orientation” sessions held for new committee members. No effort was made to offer public members specialized briefings to prepare them for their service and the day was mostly spent

explaining FDA law and regulation, how to fill out reimbursement forms, conflict of interest rules and the like. I was asked to be one of several presenters to explain the role of consumer representative. My panel was always scheduled towards the end of the day, when most in the room, secure in the knowledge they now understood how to get reimbursed, had already fled.

Now some might wonder if this lack of meaningful support for the service of public representatives is unique to the FDA advisory committee process. Well according to Dave and Becky – it is not. They know from their conversations with dozens of public members of state health professional licensing and oversight boards that a “sink or swim” mentality is the norm. Sadly, while touting the importance of public representation, those responsible appear oblivious to how this not so benign neglect sabotages the potential contributions of public members to the mission and operations of oversight bodies.

This shortcoming in support takes on added significance in light of the current emphasis on “patient engagement” in elements of health care reform legislation. Most of the reference to “patient-engagement” or the increasingly popular expansion to “patient, family and caregiver engagement” is related to the clinical experience of patients in their encounter with providers. However, there are other contexts in which such engagement is thought to be important to the success of the research enterprise. One such example arises from the government’s planned \$1.1 billion investment in Comparative Effectiveness Research (CER). While far from unanimous, there is substantial agreement among many leading researchers and it is the policy, if not yet practice, of the relevant agencies that every phase of CER should include participation by patients, families and caregivers. We are talking here about involvement at every step of the way – from start (decisions about research design) to finish (strategies for dissemination of results). But even in this instance, we still have no process in place to identify those individual patients, family members or caregivers who might best represent the public perspective about how to construct and operate the CER enterprise. And as far as I know there is as yet nothing in place to suggest how, after such individuals are identified and placed, they will be supported in their need to understand the scientific and methodological issues under discussion as well as the more practical need of being able to financially afford to participate.

Over the years, CAC has periodically tried to interest foundations and agencies in this critical need for public member support and training. While there is almost universal agreement as to the need – unfortunately there is the same unanimity in the lack of responsiveness. This failure to provide support for public members I would suggest raises some interesting questions as to the value of public representation as we know it. For example, should there be a moratorium on efforts to expand public participation until and unless there is an accompanying realistic commitment of meaningful support.

And it would be myopic not to enlarge our view to include all of the oversight and advisory activities that have been opened up to public participation over the years – no matter the sector.

As we have created more opportunities for public membership on health professional boards and other health-related venues, another critical concern is raised. There are certainly hundreds of such positions in health-related oversight and advisory bodies across the 50 states. Filling these positions with qualified candidates is a daunting task. Who are the potential public members?

Where are they? How do we find them? How do we interest them? How do we vet them?

Again, my FDA experience is instructive. I was involved for over two plus decades in FDA’s ad-hoc process for screening and nominating consumer representatives to serve on advisory committees.

What eventually became known as the Consumer Nominating Group had original representation from national consumer organizations that worked on FDA-related issues. So Public Citizen, Consumers Union, Consumer Federation of America, National Consumers League, and National Women’s Health Network were among the dozen or organizations involved. Over 20 years ago the FDA had a robust consumer affairs division and they contracted with a non-profit advocacy group to run the operations of the CNG. Meetings and discussions of candidates were always held face to face in DC and offered the opportunity for a rich selection process. In addition, a lot of effort was expended in orienting and bringing new members of the Group up to speed.

Over time, the process vaporized mainly because of the not so gradual withdrawal of resources by the FDA.

In 2010, increasingly concerned about the reality that the CNG had operated outside of the Federal Advisory Committee Act for decades (for example, its deliberations were not on the public record) and that its membership was chosen arbitrarily, the FDA decided to end the decades old process altogether. Now the process is totally transparent; consumer rep vacancies are published in the Federal Register and nominations are solicited. A list of nominees is subsequently published in the Federal Register and organizations are asked to vote.

I know that for Dave Swankin and CAC, the FDA consumer representative recruitment and selection process may have been viewed as a process gold standard – admittedly it had little if any competition. But over the years I have expressed to Dave and others my concern whether this at one time elaborate and costly process was ever worth it? After an initial period of self-congratulatory complacency, I began to wonder about the “performance” of the consumer representatives that had emerged from our process. More often than not, the FDA took our advice on candidates (the agency had the final say) and that made us feel like we had been successful in finding good people who truly would act in the public interest. But was this metric (the percent of nominee candidates we proffered that FDA accepted) the right metric with which to judge the value of the process? Probably not.

The CNG process, until its recent demise, included telephone interview with each prospective candidate conducted by a randomly assigned CNG member. The interview attempted to uncover more about the relevant experience, skills and commitment of the individual, their degree of interest in the specific committee, the ability to and comfort level for working with scientists and professionals and to be “at ease” in the difficult environment I described earlier.

The interview was obviously a well-intentioned effort to go beyond the resume and nominating letter. While we had a script of questions covering various domains and were asked to score the candidate, interviewers were free to ask additional questions. As I became more concerned about the value of our process, I developed some probing questions that I thought helpful to the task. These included asking:

1. Have you ever attended an FDA advisory committee meeting – before or after your candidacy;
2. Before or after becoming a candidate did you ever go to the FDA website and research the charter and past work of the committee; and
3. If there were controversial agenda items past or future, what did you identify as critical concerns from a public interest or public health perspective.

Sadly, the answers of most candidates did not inspire confidence. I also decided it made good sense to ask the Executive Secretaries of the various advisory committees whether or not the consumer representative we had advanced had regularly participated in their advisory committee's deliberations. More often than not I learned that they had not.

So if I had to grade the process I think it would deserve a "C" at best. It was able fairly successful at screening out those who were not appropriate as public representatives, those who lacked the commitment and time to devote to the task or who had real or perceived conflicts of interest that were not originally screened out by the federal process. But what failed to do was identify public members that would best do what we hoped: robustly represent the public interest.

Again, this is only one person's experience and in the context of the FDA process selecting public members for an advisory rather than oversight function. But it was, despite its flaws, most likely the best intentioned and for a while at least, best-resourced effort to attract high quality public member candidates and to vet them through a formal selection process.

You might ask – what does this national, federal agency process have to do with public members and state licensing boards? They are really very similar as far as process is concerned. At the state level it is usually the Governor's office (rather than an agency) that makes board appointments. Someone within the executive branch has the responsibility for soliciting candidates who are interested in filling public member vacancies. And finally there has to be a process for culling the list and making the actual appointments.

The lesson from my FDA experience is that how we design and resource the recruitment, selection and support of public members on health professional licensing boards – or any other venue for that matter – is what in large measure will determine the value of public membership in maintaining transparency and holding boards accountable. And we must get all the pieces of the puzzle right – having well qualified, but orphaned candidates will not get us there.

Thank you again to Mark, Dave, Becky and the CAC Board for this much-appreciated honor.

2011 – Catherine Dower

For her outstanding contributions to reforming the state health professional regulatory system, and especially her work to remove unjustifiable scope of practice restrictions.

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.

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.

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 20's, 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.

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, nursing homes, and so on. But the point is that she gets what I am working on, which is really exciting.

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.

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.”

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.

2012 – Paul Grace

For his outstanding leadership at the National Board for Certification in Occupational Therapy (NBCOT) in embracing and implementing many of the public interest goals that Ben Shimberg promoted and that CAC has long pursued.

Thank you. I am honored and grateful to receive the Ben Shimberg Public Service Award. The previous recipients of this award are distinguished leaders in the realm of regulation, competency, and public protection. To join this distinguished group as the 2012 recipient is both humbling and terrific.

There are three individuals who are with me tonight that I want to recognize. From the NBCOT Board of Directors is General Mack Hill. General Hill is retired from the US Army Medical Corp and serves as a public member of our Board of Directors. Mack brings to our Board the reality of the world through his experiences in military health care delivery, be it from a hilltop base in Vietnam or as commander of several US military hospitals, and now as a civilian consultant to private industry. When our board discusses topics like professional conduct, competency assessment, and standards, his exceptional career and life experience have proven to be an invaluable asset to the Board in its decision making process.

Dr. Jim Henderson is my closest friend. Jim is Vice President and Senior Psychometrician at Castle Worldwide in Raleigh, North Carolina. He has had many volunteer leadership positions throughout his career that added to the credentialing industry's body of knowledge on such topics as accreditation, standard setting, and continuing competency. He is one of the few who has mastered the art and science of psychometrics with a constant focus on fairness and quality. Most recently, he has chaired the research committee of the Institute for Credentialing Excellence.

Denise Fandel is the executive director of the Board of Certification for athletic trainers. In addition to being a trusted colleague, she is the consummate credentialing executive. She is the incoming president of the Institute for Credentialing Excellence.

Used as an adjective, crazy is defined as intensely enthusiastic, passionately excited, and intensely impatient. These are characteristics that have been used to describe individuals like Steve Jobs, Ben Shimberg, Albert Einstein, and the executive director of the Citizen Advocacy Center, Dave Swankin. Who among us would argue that David's passion for the involvement of the public in the credentialing industry isn't crazy?

"How Can the Credentialing Industry Fail?" Some may consider this question crazy. However, those who work in different aspects of the industry would not consider the question crazy; hopefully they, as I do, consider the question seriously. And often.

If we do not commit, as individual credentialing entities and as an industry, to address (and answer) this question with a focus on the end user—the public—in mind, we will have no one to blame but ourselves for a collective slow decline towards systematic irrelevance in the healthcare marketplace.

I believe it to be a safe assumption that those of us who work in this industry, regardless of our roles, have specific issues, concerns, or tipping points about the industry's health and sustainability. If left unattended, I believe issues related to leadership, governance, accreditation, and scope of practice, will shorten the timeline when our question will be answered with some finality.

I want to take this opportunity to offer some thoughts about leadership, governance, accreditation, and scope of practice, all topics pertinent to the crazy question. A certainty that we should all always be mindful of is that the private and public credentialing industry is the consequence of a political process. This process is a cradle-to-grave proposition for the individual organizational entity as well as the industry. Tip O’Neill, the former Speaker of the US House of Representatives, made the following statement famous: “All politics is local.” For me, the statement sums up my view of how, for the most part, our industry operates. A leader's success is directly tied to his ability to understand and influence the issues of his constituents, or stakeholders: the simple, even mundane and everyday concerns. For credentialing organizations, leadership means understanding who the stakeholders are and how the credential can serve their needs. Leadership means monitoring the stakeholders and developing an understanding of the influences in their environments that drive their needs. Leadership then means positioning the credential so that it satisfies stakeholder needs concerning access to and the affordability of quality care. Steven Jobs, the late leader of Apple, observed and understood the needs and interests of the computing public and then developed products that we didn’t even realize we needed.

That credentialing operates in a political environment is not necessarily a bad thing; however, it is a reality that can sometimes be challenging when we advocate for the fundamental reasons we credential individuals.

Why do we regulate the professions? The uniform response is, of course, public protection. If that is right, where and to what degree is the public included in the process before, during, and after a certification or licensure program is launched? I understand the need to establish standards for eligibility, assessment, discipline, and practice, but where is the public invested in this equation? How does the leader of a credentialing organization gain understanding of the current needs of the public and predict its future needs?

Since the early 1980’s it has become popular to add a public member to a certification or licensing board. Their role? To represent the public’s interest. For many organizations, a single public member was appointed. Think about this for a second; if one of the key roles of regulation is public protection, then why limit the public’s participation in the process to a single individual? In an industry that has a market basket full of policies and requirements and if the industry primary purpose is to serve the public’s interest, why has the industry been relatively silent on the public’s role and participation in the process? It’s safe to state the Citizen Advocacy Center has been the single most powerful voice on advocating for public members.

Why have the credentialed professions been reluctant on this key issue, other than acting on minor changes to some bylaw language?

An argument that I’ve heard is that if the decisions made by the credentialing board are good for the profession, then they must be good for the public as well.

In the governing documents of credentialing bodies—be they certification or licensure—the composition of the board is delineated: what they make up the board should be in terms of the types and qualifications of individuals who should fill certain designated positions. Why is there no specificity, for the most part, for public members? Could the public’s interests be marginalized if there is only one public member serving on a board of 10, 12, or 15 members of the regulated discipline? Is leadership

for the credential able under this arrangement to gain adequate insight into the influences that drive the public's needs and interests?

Although having a member represent the public is a requirement for accreditation of certification programs through the National Commission for Certifying Agencies and ISO 17024, there is no accreditation requirement that public members have to have the same rights and privileges as professional members of the governing body. More often than not, public members are not permitted to hold office or chair a committee, and they are often eligible to serve only on certain committees.

Why is our industry hesitant to engage the public in a meaningful way? Isn't it worthwhile having members of the public serve on practice analysis study task groups? After all, they are the primary consumers of the practitioners' services. Would public protection be enhanced if credentialing entities regularly promoted awareness to the community on how to assess practitioner's credentials or file a complaint? Will our industry ever realize the inherent power of an engaged public that can be a powerful ally in helping credentialing bodies satisfy their mission? Without industry-wide leadership that advances a proactive agenda that includes the public, this will not happen.

A cornerstone of practitioner credentialing, be it certification or licensure, is how candidates become eligible within the program. For a majority of the regulated professions, graduation from an accredited professional education program is the most significant requirement a future certificant or licensee must satisfy. At first glance, this is reasonable and promotes a common standard for all to attain. However, most of the accreditation entities for these professional education programs are linked in some way to their respective professional association.

Members of the profession make up the majority of the accrediting bodies' membership. Remember, they say—if it's good for the profession, it must also be good for the public. As I noted previously the political process has a lot of influence on how a profession credentials itself – local politics in action.

I am not aware of a single credentialed profession that was the result of anyone other than the profession's members initiating and leading the effort. I have no issue with that, but what is a bothersome fact is that usually the certification or licensing board cannot fully exercise its public protection role because of the profession's influential role in the eligibility standards. The reason for this is that eligibility standards are usually included in a practice act's language—and very specific to graduation from an accredited program.

Let's get specific with an example. We are experiencing today in health care what some have labeled "degree creep." What was once a bachelor's degree, entry-level qualification is now quite often a professional doctorate? What is the evidence that the public required such a shift in educational eligibility? Were bachelor-educated practitioners found to be incompetent? Were patients' outcomes so poor that only an advanced degree could correct the situation? Or was the driving impetus to reposition the profession among similar disciplines that share turf boundaries? What is the cost of these changes for patients and third-party payers? And was the leadership of credentialing organizations acting on a robust understanding of the public interest when considering changes to the entry-level requirement?

I am not speaking about advanced practice that might rightly require advanced education and training. I am speaking about entry-level. The change in eligibility became a reality when the profession, and subsequently the profession's accreditors, decided a change would be beneficial. I once sat in a meeting of educational program directors debating if the profession's entry level should be advanced

from the master's level to professional doctorate. One educator took the floor and announced, "We all know it has to be the doctorate—we'll have the students in class for at least an extra year and that will boost our FTE numbers!" I turned to the executive director of this group and asked him if he had a good anti-trust attorney on retainer.

I understand change is inevitable and often helpful, but what evidence should the credentialing body that represents public interests require that an accrediting body have to produce and defend when it argues for a change in entry-level eligibility to practice? Will the public be underserved by this change? What will the impact be on workforce issues, diversity, and access to care?

Much has been written about scope of practice. A rich discussion about scope of practice issues is beyond the intent of this presentation. However, discussions about public protection or public access to affordable services are, in part, about scope of practice. The scope or boundaries of practice are an integral part of the credentialing/regulatory scheme. Scope of practice defines the array of services, tools, or skills a practitioner can provide and the context where these can be provided.

In other words, it delineates the make-up and boundaries of the sand box and provides direction on who is eligible to play in their respective box.

The scope of practice model works well until another profession seeks its own sand box or wants to expand its existing box to include some of the play activities of another. In the regulatory system, this dispute is usually addressed through the political process – a process that at times appears to favor one profession over another.

In an effort to provide objectivity to the scope of practice decision making process, six health credentialing organizations came together in 2009 and published a monograph titled *Changes in Healthcare Professions Scope of Practice: Legislative Considerations*. The monograph presents questions and other factors that should be considered when determining a profession's scope.

Reasonable people can at times be unreasonable when it comes to what they consider encroachment into their profession's body of knowledge and skill or task sets. Forgotten for the most part in this process is the public.

What may not be available to the public at the end of the day may be access to efficient and cost effective care due to a turf-battle between providers.

Today in various trade publications the scope of practice of nurse anesthetists in relation to that of anesthesiologists being debated. Is the debate about any lack of education for these advanced practice nurses, inadequate training, or unreliable assessment of their knowledge and skill, or is the debate about maintaining the status quo for physicians? Again, if it is good for the profession it must be good for the public.

With the coming changes in health care delivery, credentialing bodies and the credentialing industry need to be an independent and objective voice in helping the system work through challenges inherent to scope of practice, governance, and accreditation. There are other issues that require leadership: professional discipline, telemedicine, continuing competency, and funding. Lack of an industry-wide focus to these and other issues can marginalize our impact on influencing health care delivery. If the public and private entities that make up this industry are to be successful in their public service

mission, the number one need is focused, informed, and courageous leadership. We all know when an organization has it, and unfortunately, we may all suffer when it doesn't.

In our lifetime, there may not have been an individual who has made a greater impact on how we live and work than Steve Jobs—that crazy guy who founded Apple Computer. He invented the future for us in the development of devices that we might not even have imagined were possible, and as a result, he gave us access—affordable access to the world of information to a degree that has improved our lives.

Most, if not all of us have used or watched someone use the Apple iPhone or iPad. With one touch of a colorful icon or swipe of the screen we are now able book a flight, make a reservation, play poker, and try to win at Angry Birds. In his HBR article, Jobs biographer Walter Isaacson describes some specific leadership applications that Jobs used to lead Apple. We would be crazy not to consider these and their potential impact and changes to the way we approach our credentialing business. I want to discuss a few of these leadership characteristics.

In preparation for this presentation, I did a search of Steve Jobs quotes about life and business, drawing significantly on Isaacson's work. All, I believe, all have a common element – leadership.

So now I'd like to ask my crazy question another way, "How Would Have Steve Jobs led the credentialing industry?"

Focus – Deciding what *not* to do is more important than deciding what to do. As Jobs said to the CEO of Google – "Figure out what Google wants to be when it grows up." For our industry, our focus is public protection. We need to figure out what the needs of the public will be in a continually evolving health care service environment and to set standards and credentialing policy that supports the public's need for quality, access, and affordability. What are we doing to stay focused on this goal? What forces do we need to stand up against to achieve it?

Simplify – Jobs' ability to focus was accompanied by his related instinct to simplify. "It takes a lot of hard work to make something simple," he told Isaacson. Are our rules and regulations too complex, resulting in confusion or misinterpretation by those we credential? Think about the instructions you receive when you purchase an Apple product: connect the device to a power source and begin. Can the public understand our systems and guidelines?

Push for Perfection – During the development of every product, Jobs at a certain point "hit the pause button and went back to the drawing board because he "felt" it wasn't perfect. How often do we hear that we can work on the corrections to a product, process, or policy at a later date?

What message is an organization sending, especially a credentialing one, if it appears to be routinely issuing correction or interpretation announcements to its credential holders and related communities?

Engage Face-to Face – Jobs was a believer in face-to face meetings. There is temptation in the networked age to think that ideas can be developed by e-mail, he told Isaacson. "That's crazy. Creativity comes from random discussions. You run into someone and ask what they are doing, you say "Wow," and soon you are cooking up all sorts of ideas." Unfortunately, today's financial challenges may limit or eliminate a board's (or its key committees) ability to meet face to face.

However, engaging with others face-to-face is for me is like setting the stage for a play or movie. We will never know what our industry would be like today or tomorrow if Steve Jobs was its leader. I am certain it would not fail under his leadership.

For us, today's leaders in credentialing, to develop answers to the question "how can we fail" is the collective responsibility of credentialing bodies and meaningful public participants to address.

Through respectful leadership, it requires a commitment to serve our primary customer, the public, a commitment to base decisions and actions on evidence, and collaboration may change the question from failure to success. I don't consider that to be too crazy an idea.

Thank you.

2013 – Kathy Apple

For promoting best practices in nursing regulation and motivating boards of nursing to regularly evaluate and improve their performance as protectors of the public interest.

Thank you for that kind introduction. I have to start by saying how humbled and honored I am to receive the Ben Shimberg Public Service Award. I am overwhelmed to be acknowledged with this award and in awe of its past recipients, for all of whom I have great admiration and respect.

I want to thank the CAC Board of Directors for their consideration, with a special thank you to David Swankin and Becky LeBuhn who have had a positive and substantial impact on my regulatory career.

I know I am supposed to provide a lecture at this juncture. I did prepare by reviewing all of the previous award lectures and noted that Art Levin said that he would not give a lecture but then went on to give an outstanding one. I would like to do something a little different by sharing the experiences and lessons that have shaped my regulatory career and the beliefs I hold today about the importance of public protection through licensure and the proper role of the regulator. I have titled my lecture: *The Reluctant Regulator: Lessons Learned on the Importance of Public Protection*.

In my educational endeavors and throughout my professional career, I have always sought experiences that were challenging, stimulating, and in one way or another, gave back to the community at large. Seeking those opportunities did not always mean I knew everything I was supposed to know. At least I knew that I did not know, and so I always sought out new knowledge. Somewhere early in my regulatory career, I obtained a copy of Ben Shimberg's book, *Occupational Licensing: Practices and Policies*. I also had the privilege of meeting Dr. Shimberg. I wish I had known him longer. I wish that I could sit down with him now, knowing what I know today.

I started my regulatory career not as a regulator but as a regulated professional. In 1989, I moved from Alaska to Nevada. I thought I was being a responsible registered nurse by applying for both my registered nurse and advanced practice registered nurse (APRN) licenses prior to my move. The Nevada State Board of Nursing issued a RN license but denied the APRN license. I remember wondering why I was okay to practice and be licensed in one state but not another.

On the surface, it did not make sense. I appealed the denial of the APRN license three times appearing before the board of nursing three times. I don't know if that is stubborn determination but in the end, after completing a second master's degree as recommended by the board of nursing, they offered me a job. Looking back, I am not sure exactly how that happened. I was told I did such a good job during my appeals, that the board of nursing was impressed, even if they could not give me what I wanted. However, what I know now is that as a professional nurse, I did not really understand the public protection purpose of licensing and the professional obligation under law, let alone administrative law and the construct of law.

What I came to understand later was that the state nurse practice act was not clear on how to regulate advanced practice in psychiatric-mental health nursing. This lack of clarity was one of the first things I helped make clear through changes in law and regulation once I was hired. I learned how to change the law to protect the public while at the same time providing access to qualified providers. It was my first lesson on how to evolve nursing regulation and the importance of regulatory evolution. There would be many other lessons along the way regarding regulatory evolution including arguing the public protection case in the five-year discussion that resulted in the first nationally standardized

regulatory model for APRNs known as the Consensus Model for APRN Regulation. This model which is currently being implemented in all states, protects the public, while at the same time provides increased access to care and improves the mobility of APRNs.

The original position I was offered by the Nevada State Board of Nursing was the Associate Director for Discipline. I remember thinking how hard could this job be? After all, nurses are good people. Year after year Gallup Polls reveal that nurses are the public's number one most trusted profession. However, little did I know the types of unprofessional conduct and incompetence that could threaten or actually harm patients.

Now I want to share a story that may appear at first glance not to connect to what I just said but bear with me, it will. Prior to starting this new position, my husband and I went on a four-day river rafting trip with several other couples from his place of employment. We all met at an agreed upon location and began setting up camp for the night. Someone built a campfire which brought everyone together, as campfires do. I was sitting next to a woman who during the course of introducing each other, discovered we were both nurses. This is always an energizing moment when in a group of strangers, you find commonality. I found out she worked at a local acute care facility. When she asked me where I worked, I said I was about to start a new position with the Nevada State Board of Nursing running their discipline program. Well, so much for commonality, the first thing she did was get a horrified look on her face, and then promptly got up and left. I hardly saw her during the rest of the trip. I wondered what I had gotten myself into with this new position. A year after I started with the board of nursing, I was going through some old investigative files and lo and behold, there she was, the same nurse I shared a campfire with. There had been a complaint of possible drug diversion filed against her. That investigation had been closed for lack of evidence but a year after that she was reported to the board of nursing for falsifying prescriptions for controlled substances. At least I had now understood her initial reaction when we met on the banks of the American River. Lesson number two: I realized later that it is human nature at play in this framework of public protection. After all, if all human beings were ethical and law abiding, there would be little need for regulation.

Managing the state board discipline program was my first visceral insight and lesson on how professional licensing protects the public. At the time I started, the board of nursing had a backlog of discipline cases and the Attorney General had been asked to assign a deputy attorney who was a skilled litigator to assist in aggressively moving this backlog. The first case the new deputy and I reviewed was about a new nurse who after being fired at a local hospital for a pattern of medication errors, had threatened to "blow away the unit" where he worked. The deputy and I became immersed in a very heated debate about the merits of the case and public safety. While the deputy thought the nurse was just blowing off steam, I knew that this was a credible threat.

In the end, we came to an agreed upon action plan, which included the deputy teaching me administrative law and me teaching him about nursing practice with a special focus on mental health issues. Through the course of our working relationship we had a clear sense of the boundaries of our roles and how they complemented one another. Lesson number three: After years of seeing one horrific complaint after another, I came to believe that the disciplinary function of licensing boards is critical, vital, and as needed today as it will continue to be in the future. The experience also taught me how respecting and acknowledging legal scopes of practice between and among professionals works for the benefit of all.

Later, after I was offered the position of executive director for the Nevada State Board of Nursing, I decided to contact a previous executive director who had been well respected in the state. Because she was elderly, I offered to come to her home explaining that I was seeking her seasoned advice on the role. She immediately and forcefully said no, that she would be in my office at 9:00 a.m. sharp the following morning. And she was. Her opening comment to me was about power; who has it, who doesn't, how to respect it, how to use it, and how not to be corrupted by it. It was a conversation I was not expecting; however, it was the most important advice I have ever received. Lesson number four: It is a powerful position to implement law, with the force of law, but it must be done respectfully, judiciously and fairly.

This brings me back to the individual for whom this honor is named. Here is what I learned from Ben Shimberg: - ask questions; all kinds of questions, fundamental questions, even questions for which you think you know the answer. Why is there licensing? Who should do the licensing?

How are licensing requirements determined? How is competence determined? What is the best way to determine competence? And my favorite, where is the evidence that licensing works?

Lesson number five: Asking the right questions often is the answer to evolving licensure regulation.

Dr. Shimberg was an expert on competency testing. He challenged us all to ensure competence assessments meet the highest psychometric and ethical standards. He urged licensing boards to continuously examine how to improve testing procedures. Dr. Shimberg challenged licensing boards to improve communication to applicants and consumers, to keep data and accurate records on all board business and be accountable for their own performance. He advocated for research conducted by licensing boards in all aspects of regulatory functions. He encouraged collaboration between and among licensing agencies. He challenged all regulators to have and follow their own code of ethics.

Dr. Shimberg influenced many nurse regulators and I think he would be pleased with the many accomplishments of NCSBN such as the emphasis on evidence-based regulation, commitment to ongoing regulatory excellence through the collection of performance data, research related to nursing regulation, psychometrically sound and legally defensible competence assessments, an organizational value of collaboration especially with regulatory bodies of other health care disciplines, and learning through interaction with regulatory bodies from other countries.

Here is what I continue to learn from CAC: Ask more questions.

I heard about the Citizen Advocacy Center early in my regulatory career; I knew it was a consumer advocacy organization and provided education for consumer members of licensing boards. I attended annual meetings, listened, learned, and was stimulated by the sophisticated dialogue. I learned about the critical importance for the role of consumer members on licensing boards. When David Swankin asked me to sit on a discussion panel, I was unprepared for what would unfold. This is where I learned about the true genius of CAC. The panel discussion was on collaboration between health care licensing boards. David did not ask the panelists to discuss collaboration, he did not ask us to share why health care licensing boards do not get along. He simply asked us to share how our respective regulatory bodies work positively together. I shared the panel with a representative from the Federation of State Medical Boards. I have to confess that I was scrambling; how did we work positively together? It was an awkward panel discussion at best. Today however, I am happy to report that NCSBN led the way to the formation of the Tri-Regulator Leadership Collaborative with the Federation of State Medical Boards and the National Association of Boards of Pharmacy. This

collaborative is working in a very positive, collegial manner on issues of mutual concern and modeling interprofessional collaboration at the national level for our members at the state level.

There is still much work to be done in our field of regulating occupations and professions through the concept of licensure. I recently read a new study published in the *Journal of Patient Safety* in September of this year titled, “A New, Evidence-Based Estimate of Patient Harms Associated with Hospital Care.” The conclusion of this study was that the number of premature deaths associated with preventable harm to patients in this country was estimated at 210,000 to 400,000 per year. This is two to four times the estimate cited in the Institute of Medicine report, *To Err is Human – Building a Safer Health System* published in the year 2000. Here is my question. What happened? Why have all the efforts for improvement made by so many appeared to not have the desired impact? One of the comments from the report was that “the lack of a well-integrated and comprehensive continuing education system in the health professions is a major contributing factor to knowledge and performance deficiencies at the individual and system level.” Clearly preventing adverse events is a complex subject that includes both system and individual errors. Regarding individual errors, I do find it interesting that this report readily identifies what I believe to be the unanswered question of our generation of regulators: how should the licensee demonstrate competence over time in order to maintain the privilege of licensure? This question was raised 10 years ago in the 2003 Institute of Medicine report, *Health Professions Education: A Bridge to Quality*. This report recommended that all health profession boards should move toward requiring licensed health professionals to demonstrate periodically their ability to deliver patient care through direct measures of technical competence, patient assessment, evaluation of patient outcomes and other evidence-based assessment methods. So why is this such a hard question? What stops the regulatory community from taking decisive action? Should not the public and regulatory bodies demand the same standard of competence assessment of the licensee from the beginning, and throughout the lifetime of active practice? Should we be rethinking how health care professionals are licensed? Is the generalist licensure model still the right model? Now see, this is where I think Ben Shimberg would be proud that all of us keep asking questions.

In closing, I have had the honor to learn many lessons, that collaboration is an absolute necessity; that the essence of human nature influences regulation; that the law must be clear, just, decisive and must evolve, to be aware of power and use it wisely; and most importantly, keep asking questions.

I would like to end by expressing my gratitude to the CAC Board of Directors for this honor, to my many colleagues at the National Council of State Boards of Nursing, and to my many mentors, some of whom are in this room, and lastly and most importantly to Ben Shimberg who urged us all to do our best in protecting the public.

2014 – PROPUBLICA

For informing and protecting the public through in-depth research and incisive reporting about shortcomings in our healthcare system and oversight institutions.

Charles Ornstein and Tracy Weber accepted the award on behalf of ProPublica and delivered the following Ben Shimberg Memorial Lecture:

Charles Ornstein

In many ways the Citizen Advocacy Center and ProPublica have a lot in common because we both focus on accountability, effectiveness, and transparency. ProPublica was founded to promote accountability journalism. We were founded also to bring about transparency in what we do as journalists and also in government operations. One thing that makes ProPublica unique is that we not only talk about transparency, we live it in what we do. So, we are deeply honored to be here to share our story with you tonight.

We are journalists, so let us start with stories. Here is one about a nurse named Orphea Wilson. She got her nursing license initially in Connecticut. As many healthcare professionals do, Orphea moved to another state, Florida. While there, she cared for a 21-month old boy who stopped breathing. Instead of calling 911, Orphea tried CPR on her own and then drove the boy's limp body three miles to his parents' home by which time he was dead. She lost her nursing license in Florida in 2004. Remember, she endorsed into Florida from Connecticut. So, she returned to Connecticut to work there as a nurse. In 2005, she was caring for a three-year old boy who suffered from chronic respiratory failure and muscular dystrophy. He stopped breathing, as well. While the boy's father raced to his side and began performing CPR, Orphea stood by. It was too late and the boy died in the hospital the next day. Orphea lost her nursing license in Connecticut and went to prison.

What happened with Orphea Wilson could have been stopped. The State of Connecticut relied on nurses, including Ms. Wilson, to tell the truth on their renewal applications about the status of their licenses in other states. The State of Florida didn't see fit to tell Connecticut because it viewed it as another state's responsibility to know whether a nurse had been disciplined. Two states took different positions on this and two children died. To us, this symbolizes the importance of the work we are doing and also the importance of the work that CAC and licensing boards are doing. This is not a hypothetical or theoretical issue. The lives at stake are very real and the decisions that health professional licensing boards make on a day-to-day basis and in their policy decisions have the potential to impact the lives of children.

We did not initially intend to investigate the California Board of Registered Nursing. For a number of years Tracy and I had been covering a troubled hospital in South Los Angeles called King Drew Medical Center. This hospital served a poor community in South Central Los Angeles that was transitioning from being predominantly African-American to being predominantly Hispanic. We found that this hospital was harming the very people it was intended to help. In fact, some of the actions were deliberate. We wrote stories in 2003, 2004, 2005, 2006 and 2007 about actions taken at the hospital that harmed patients. We named individual caregivers who were responsible and who were terminated as a result.

One nurse turned down a patient's monitor because they were tired of hearing it alarm. The patient died, but the nurse pre-charted to indicate they had checked on the patient even at a time when the patient was dead. Another nurse gave an anti-cancer medication to a patient with meningitis and also was found to have turned down the alarm on a monitor. Another nurse ignored a patient while she was undergoing dialysis and the dialysis catheter came lose and was spurting blood across the room. Another nurse was fired because she falsified the CPR certification cards for employees at the hospital.

These are nurses whose discipline was upheld by independent arbiters. As Tracy and I wrote about these and other stories, including ones about organ transplant centers, we kept looking at the California nursing board's Web site to see whatever happened to these nurses. It was a great surprise to us that nothing happened to these nurses – at least right away. The questions that we had when we wrote these stories were these, "Is this a function of King Drew, or is this a function of nursing oversight in California? Is it that the hospital wasn't reporting discipline to the nursing board, or is there a bigger issue at play with the nursing board?"

We decided to build a database of every nurse who had been disciplined in California over the course of seven years. There were more than 2,000 in all. We hand-entered each of these disciplinary actions into our own database. One of the things we learned is that in California, the nursing board signs off on every discipline. So, board members presumably read these cases and signed off on them.

One thing became very clear as we went through the database: in California it took an average of 1,254 days from the point of a complaint to the issuance of discipline of a nurse. By way of comparison, in Texas, it took 173 days and in Arizona, it took 197. So California was taking five or six times longer to impose discipline and during that time, nurses were able to work in multiple hospitals.

We found nurses like Owen J. Murphy, who twisted the jaw of one patient until he screamed and picked up a frail elderly man by the shoulders and slammed him against the mattress. He was fired from his job and reported to the nursing board, but was able to get another job at another hospital. At this other hospital, he beat up patients and was convicted for it. He then got a job at another hospital where he was fired for pulling out patients' hair. When Tracy caught up with him, he was working at a fourth hospital. He had taken anger management courses, but he told Tracy, "The nursing board is there to protect the public from me." This is a very telling quote from an individual like Murphy talking about the professional licensing board's responsibility. Indeed, if your state is anything like California and your board is anything like California's nursing board, the preamble to your law reads something like this: "Protection of the public shall be the highest priority for the Board of Registered Nursing in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount."

Think about your boards. Is the protection of the public paramount in what you do? Or, is the interest of the profession, including its interest in protecting its scope of practice, paramount in the decisions being made? When we went to meetings of the Board of Registered Nursing in California, what struck us was that we were the only ones there, other than union representatives representing the interests of the profession. The public wasn't there. What also struck us was that nobody on the board – not the staff members, nor the licensee members, nor the public members – asked questions about why it was that it took so long to discipline nurses. Why was it that they were looking at cases where the offense had taken place ten years earlier? Why was it that they were looking at a case where a nurse was able

to get in trouble at five hospitals before the nursing board took action? These questions weren't asked at any of the meetings we attended.

We also looked at California's program for drug-addicted professionals. It is a lofty mission to help these people overcome their addictions rather than ending their careers. One of the things that we found was that, again, the protection of the public was secondary to the protection of the profession's interests. As may be the case in your states, California's program is confidential. In exchange for the board not pursuing discipline, the nurse agrees to the conditions set forth in a contract with the diversion program. Essentially, nurses voluntarily agreed not to work. But, the board's Web site showed that their licenses were active. When nurses were terminated from the diversion program, they were sometimes labeled a public safety threat. The problem was, the board didn't tell the public. It took an average of 15 months for the board to file accusations against these nurses. In the meantime, they were able to find work.

Tracy talked to another nurse named Tiffany Farney who had been enrolled in the diversion program after stealing and using painkillers. She was labeled a public safety risk in December 2005. The board didn't file its accusation against the nurse until January 2009. During the intervening time, she logged at least two arrests on drug-related charges. She told Tracy, "They terminate you. They say you are a danger to public society. Then it takes three years for them to do anything. The nursing board should be all over me like a hawk. An addict, you've got to watch them like a baby." This is a person in the program. The board put its faith in the addicts and allowed them to control the rules of the program.

I talked to another nurse in the program named Annette Aquilias. She was in the diversion program because she sold drugs. Officially, she couldn't work without the board's permission, but she knew nothing would stop her. She told me, "I thought, this is good. I need to work. I need to pay my bills." She got an unauthorized job as a temporary nurse at a hospital and pleaded guilty to stealing Demerol on her first (and also her last) day. The hospital reported her to the board, but she remained in the diversion program. Months later, she got another job without permission. At this hospital, she appeared high and was accused of leaving a critically ill patient unattended. Two days later, she was kicked out of the diversion program. But, guess what, she got another job and stole drugs before the board filed the accusation against her. All told, it took three years to bring this case to fruition.

Another thing we found was that temporary staffing agencies were empowering these healthcare professionals. The level of protection they provided to the public was definitely inferior. We found that temp agencies shuffled nurses from one hospital to another, even as complaints mounted. We found one staffing agency that sent a nurse to hospitals despite more than a dozen warnings that she was ignoring her patients and sleeping on the job. Before she was hired, that nurse had been convicted of twelve crimes, including prostitution, carrying a concealed weapon, and possessing cocaine.

Nurses who got in trouble at one agency had no trouble landing a job at another. We found one Oklahoma nurse who cycled through at least four Southern California agencies in a year while being accused of pilfering drugs at each. Before her final stop, she was arrested in her home state for posing as a doctor's office employee and calling in prescriptions.

Nothing was being done to look at these temp agencies because the nursing board didn't view it as their job to regulate temp agencies. We came across a deposition in which a CEO of one of the temp agencies was asked about how they find and interview nurses.

Question: “Do you speak to the prospective nurse before hiring them?”

Answer: “Not necessarily.”

Question: “More often than not or less often than not?”

Answer: “Less often.”

Question: “Infrequently?”

Answer: “Hard to say. I certainly didn’t speak to every nurse.”

Question: “How about meeting a particular nurse?”

Answer: “Never.”

Health professional licensing boards have a responsibility, we think, to pursue these sorts of things and determine whether they contribute to problematic healthcare professionals in your states, whether in nursing or other professions.

We also looked at healthcare professionals with criminal records and found that in California there is a rule that nurses licensed after 1990 must be fingerprinted, but nurses licensed before then don’t need to be. What we found was that hundreds of nurses licensed before 1990 were getting arrested, but the board didn’t know anything about it. Only after our story ran did the board require that all nurses be fingerprinted. I think the board was quite surprised by the immense number of arrest reports they received.

The ultimate conclusion is that the board operated with a philosophy of trust the health professional. Our philosophy as journalists is trusting is fine, but you have to verify. Trusting and verifying are essential parts of our job and I would argue they are essential to every job. The lessons we learned covering the California nursing board have broad applications to our future reporting, which Tracy will tell you about.

Tracy Weber

After we investigated the nursing board, we decided to look at relationships between drug companies and physicians. We have a database on our Web site called “Dollars for Docs.” It shows payments by drug companies to healthcare professionals for speaking and consulting.

You can look up a doctor and see whether he or she received money from a drug company and for what and how much. We ran the top-paid doctors through the disciplinary boards and found that a lot of the doctors who received money for speaking and consulting were also disciplined doctors.

The Dollars for Docs project made us curious about who monitors the prescribing patterns of doctors and nurses. This was not a popular inquiry. The medical profession doesn’t believe one should question what doctors and nurses prescribe or what procedures they perform.

Nevertheless, we met with Medicare and persuaded them to give us data about prescriptions written for patients in Medicare’s Part D program.

After enormous amounts of research about which drugs are dangerous for patients over 65, we added data to our Web site called “Prescriber Checkup.” You can look up a doctor’s name and see what drugs he or she prescribes and in what frequency. You can determine whether they prescribe drugs that are dangerous for patients over 65 and can compare their prescription pattern to others in the same specialty.

Of the top twenty prescribers of addictive painkillers, more than half had been disciplined or arrested and convicted. Yet, they were still prescribing in Medicare. Many had been arrested but not disciplined by their medical boards. This was a red flag that something is wrong.

Neither Medicare nor licensing boards were looking at this data. When we asked medical boards about this, they told us several different things: “This is not our job.” “We don’t see complaints about this.” “We don’t have anyone qualified to do this.” “We don’t have access to the data.”

The case of Chicago psychiatrist Dr. Michael Reinstein illustrates what the data reveals. One of our ProPublica colleagues teamed with the Chicago Tribune in 2009 and wrote about this doctor. The doctor worked with a chain of homes treating people with schizophrenia where he was prescribing tens of thousands of doses of Clozapine, a toxic and risky drug. We could see in the data that he was prescribing more than twice as much of this drug as his colleagues.

There were numerous complaints about Dr. Reinstein, but the medical board took no action against him until three years after our story.

Another doctor popped up in our data for prescribing 8,000 doses of Seroquel to patients over 65. Most of his patients were dementia patients in assisted living facilities. There is a black box warning on the medication saying it is really risky for dementia patients. These are incredibly vulnerable bed-ridden patients who don’t have a voice and they were being drugged. This doctor had been kicked out of Medicaid in Florida for incompetence. Still there was no discipline on his medical board record in Florida.

Another doctor in Texas, Dr. Lewis, was the medical director for a string of nursing homes. We found multiple judgments against him, including one for \$1.6 million involving the death of a patient. This case was not on his medical board record. Maybe licensing boards should run their doctors through ProPublica’s Prescriber Checkup.

We have another database called “Treatment Tracker,” which contains data on patients in Medicare Part B. You can look up how many procedures doctors are performing. You can see when a doctor is doing only the most expensive procedures or is claiming to do an impossibly large number of procedures.

The point is we now have lots of data. It is public data. Regulators should be looking at it. We interviewed patients and staffers and doctors. We found massive fraud in the Medicare program. This also should be looked at. Regulatory boards are a safety net. People go to your Web sites and when they find nothing, they feel good about the practitioner.

We found hundreds of doctors in Treatment Tracker who were billing only for the most expensive procedures. We have another database of referrals. Several of the most referred to doctors are being investigated or are already in jail for fraud.

Talk within your boards about how you are going to use all this data that is now available. What are your responsibilities? The Sunshine Act will reveal even more documentation. Boards often look at the low hanging fruit such as DUIs and other states' discipline. Cases involving quality and competence are harder, but perhaps more worth pursuing.

Charlie and I have been thinking about some of the questions boards we think boards could ask themselves, given our experience talking with boards across the country:

Does your board post disciplinary data online? That enables everyone to look at accusations and disciplinary records. Nine medical boards and eight nursing boards still don't do this.

Does your board check with other states to see whether or not nurses in your state are being disciplined elsewhere? We found that not all states in the compact have the same disciplinary standards.

Do you ask questions, especially if you are a public member? As a public member, you see things that members of the profession may not see. You have to feel free to speak up and ask why it took so much time to pursue a case, or what allowed an offender to move to three hospitals before our board did anything about it.

What is your policy if someone is not complying with the terms of a diversion program? How quickly can your board react? Some states automatically revoke the licenses of professionals who fail. When we started looking at the California nursing board, we were told it was the best in the country and that its diversion program was the best. This turned out to be untrue.

We found things that weren't apparent from the outside.

Do you have a rigorous system for prioritizing cases? If a case comes in where patients are being put at risk, does that get immediate attention? It seems really basic to treat these cases first, but it doesn't happen everywhere. How do you flag those cases? How do you make sure they are assigned to a top investigator?

A judge once called me to take a look at a Los Angeles Juvenile Court system because he couldn't get people to pay attention to how bad the problems were. Sometimes systems need outside scrutiny. Sometimes you need someone to write about what is happening in order to get appropriations or focus attention to fix a problem. Sometimes problems are cultural. It isn't easy to shake things up.

Thank you.

2015 – Lisa McGiffert

For her advocacy and success in mobilizing consumers and patients to represent the public interest before licensing boards and in other settings.

Transparency in Patient Safety – Seeing Is Believing

I am so honored to be singled out for the Ben Shimberg award among the many people who work across the country to try to keep patients safe by improving the oversight of health professionals. It is a particular privilege to be listed with those I admire personally and have had the opportunity to work beside such as Art Levin and Julie D’Angelo Fellmeth.

I met Art more than 20 years ago when I joined a committee of consumer organizations that vetted candidates for consumer representatives on FDA advisory committees. We immediately connected as fellow travelers on this path of including the public interest voice in all facets of our nation’s health regulatory system.

And, Julie entered my orbit about six years ago when we began monitoring the Medical Board of California (MBC). We were quickly introduced to her extraordinary body of work – years of persistently and intelligently monitoring the board. The board respects her opinion, they listen to her, and often they do what she asks because they know she is solidly committed to ensuring they are accountable to the people of California. I wish every state had a Julie Fellmeth.

And, thank you for the opportunity to “meet” Ben Shimberg– who was fundamentally about regulation in the public interest and spent his life working toward that purpose. I am so honored to be introduced to and connected to his work in this way.

As you heard, I work for Consumer Reports – we are a nonprofit organization that tests and rates products and publishes the results. Through our advocacy and policy arm – Consumers Union – we push for changes in the marketplace and in laws so they tilt more in the favor of consumers. For the past 14 years, I have directed the Safe Patient Project. We work on an array of issues – health care-acquired infections, medical errors, safety of medical devices and physician accountability.

Our ultimate goal is to eliminate preventable patient and we do so by seeking policy changes that make medical errors and the risk of harm more transparent to the public. That in turn motivates health care providers, and sometimes their regulators, to act differently. Working alongside of me to meet these goals are Consumers Union staffers Suzanne Henry and Daniela Nunez – their research, tweeting, organizing, story collecting and analyzing is what makes the wheels of our Safe Patient Project turn. I want you to recognize that I share this award with them. And, with consultant Maryann O’Sullivan, an extraordinary combo of organizer/policy wonk, who has been instrumental in keeping us moving forward on California medical board work.

I am especially pleased to be recognized for my work mobilizing consumers and patients to speak up for the public before medical boards. Over the years we have collected more than 6000 stories from people who have experienced medical errors up close and personal. These story sharers have helped us build a network of citizen activists from all over the country – now called the Patient Safety Action Network. This is an amazing and remarkable group. They are members of a club that none of them wanted to join and they are passionate about preventing others from experiencing what they did. At least one of them is speaking out and taking action every day to make our health care system safer. They are involved in all of our work and we are often involved in their efforts. For example, last year

they formed an ad hoc Medical Board Roundtable -- we meet monthly to share information and ideas about how to make our states' licensing boards more responsive to the needs of consumers and patients.

Working with this network is the best part of my job. They keep me focused on what is really important: staying on the side of patients and not getting distracted by the much more visible and ubiquitous issues concerning doctors and hospitals. Health care providers do have issues that I might be sympathetic to and there is a lot needed to be done to improve their experiences working in the health care system. But they have other people to advocate for them. My job is to advocate for what patients and the broader consuming public needs and that sometimes conflicts with what health care providers need and want. I get really peeved when consumer advocates are lured away from the focus on patients – often through funding sources that direct them to work on provider issues. There are simply not enough of us. So we have to stay focused. As public members of occupational licensing boards – you have a similar responsibility.

My first introduction to physician accountability issues was in the late 1980's. I was a staffer for the Texas Senate Committee on Health and Human Services. My boss was one of the sponsors of a bill to incorporate changes required by the federal Health Care Quality Improvement Act – the law that created the National Practitioner Data Bank. This bill allowed the Medical Practices Act to be completely opened for debate. The negotiations were intense and I learned a lot about occupational regulation that year. In subsequent years I worked on many issues relating to the whole array of state oversight boards - nurses, pharmacists, dentists.

When I moved over to Consumers Union's Austin based Southwest Office in 1991, I took these regulatory accountability issues with me and continued to monitor and work to improve how boards interact with the public and to make their work more transparent to the public. In 2003, I turned my attention to public reporting of hospital-acquired infections – we were instrumental in passing 30 state laws, after which the federal government required all US hospitals to report certain infections. Without knowing where these problems are, we cannot address them. We are now seeing some of these infection rates coming down. And one of the major factors in making that happen was transparency. The pressure brought by public awareness can be great. In 2009, physician accountability issues returned to my repertoire – and transparency is a major part of that work.

An early lesson learned in my life as an advocate was that information is power. And without information, the public is powerless. I think ultimately transparency is a primary issue in patient safety, including oversight of health professionals. In its truest form, transparency requires making the information easily available to the public without arbitrary barriers – the Internet has really helped us there. But to achieve real transparency also requires promoting to consumers where to find information, translating what the information means and how they can use it.

We recently filed an administrative petition asking the Medical Board of CA (MBC) to require all physicians on probation to inform their patients of their probationary status. The board does this sometimes in probation orders, but not consistently. We wanted this notice to be a standard part of probation orders.

For several years we had been asking the board to discuss this issue that had actually been raised by board staff as a 2012 Sunset review recommendation, but rejected by the board.

Unfortunately, the board wouldn't put this issue on their agenda, which is the only way they could discuss it. So we filed this petition -- California law requires state agencies to respond to such a petition within 30 days. That's how we got our day before the Medical Board.

I realized that this proposal and the board's response highlights many common frustrations that consumers and patients have with health licensing agencies in general and medical boards in particular.

The first basic issue raised: What does "public information" look like and what does it mean to board members who are directed to serve the public? These days, health licensing boards embrace the public's right to know and are proud of the information they have posted on their websites.

I have to take a minute to say that there is much to be proud of. It is much easier to get public information today than when I began working on these issues. It was a huge victory when the Texas Medical Board finally posted disciplinary orders on the website. But the documents were in some obscure and difficult format, instead of the universally used pdf format.

In general, these websites could be a lot more consumer friendly and we know that is not always under board control. But, boards seem to be okay with people having to work at "knowing." They don't make it easy and often create unnecessary barriers, for example: the link to many states' profiles is labeled "verify a license" or "look up a license" -- when "look up your doctor" would be so much more understandable. Many websites have legal disclaimers that would make the average consumer think that the information was not correct, even information created by the board. And, there is typically no plain English summary about why a physician is on probation. So, even when consumers find their way to the medical board website, they face a complicated array of pages and links to get to a profile and then they have to wade through long legal documents that are nearly impossible for them to interpret. I don't believe this scenario fulfills the mission of truly informing the public.

We asked the CA Medical Board for the list of all 500 physicians on probation. We sorted the spreadsheet by county and posted it on our website. We sent a news release out to the media and they really responded. The spreadsheet included a link to each physician's probationary order so reporters could read for themselves what led to this disciplinary action. And they were shocked that some of these doctors were still practicing on patients who had no knowledge of these actions. This didn't really surprise us because Consumer Reports had surveyed the public several years ago and found that 79% of respondents thought that when physicians' licenses are limited, suspended or revoked, they should be restricted to work that does not require patient care or treatment until their licenses are in good standing again. Clearly an opinion that contradicts the California medical board's practices.

Consumers Union made it easy for the media and the public to see which doctors in their community were on probation. The media coverage before the board meeting was off the charts -- with newspapers editorializing in support, radio talk shows and interviews with consumers and board members about the patients' right to know. As a consequence, many more people discovered that the medical board website was a source of important information.

Another issue: The board seemed more concerned about the burden on a few doctors to disclose their probationary status due to their behavior than for the potential risk to their patients who may be harmed. The board was concerned that this would interfere with the doctor-patient relationship. If a doctor on probation for repeated gross negligence or serious substance abuse issues harms a patient, it is the ultimate betrayal of trust if that patient was unaware of the doctor's prior discipline.

A license is a privilege. Doctors on probation have violated that privilege. This involves a very slim minority of doctors – why are boards and the overwhelming majority of physicians who never would have these problems shielding these doctors?

The board was concerned that if patients were told about a doctor's probation, they would no longer want to see that doctor. But this was insultingly flawed reasoning because the board openly stated that all patients had to do was to go to the website and find this information. We thought it was certainly more efficient for the patients of a very small percentage of licensed doctors to be informed than to expect millions of people to check on more than 100,000 doctors' backgrounds every few weeks to keep up with the medical board's actions.

Misinformation. The board members and the medical community didn't seem well informed about common behavior that lands a doctor on probation. Instead, they focused on doctors on probation for minor issues such as recordkeeping and tax issues (in reviewing orders, we have found none of those). Their focus should have been on the ones who have substantially violated medical practice standards or committed egregious acts that any patient would want to know about, has a right to know and can know if only they have a computer to look it up and the tenacity to wade through the maze of pages and documents. We were so concerned about this misinformation being provided to the public by the so-called experts that we asked the Board to analyze their probation orders and report on how many are on probation for serious issues like sexual misconduct or repeated gross negligence.

In addition to the concerns already mentioned, the medical board thought our petition was too prescriptive – it outlined how notice should be given, some of which we took directly from Board orders – and they voted to deny our petition. But they got the message that the public wants to know about these things. They adopted motions to continue working on this with Consumers Union and other stakeholders. So, we feel real progress was made toward patient and board awareness. The Board is also doing more outreach to inform the public about who they are and what they do -- and plans to expand that in the future. We are very happy to see these efforts and will be working with the board to get the word out.

We will be going back to the board to ask them to require doctors to inform their patients when their probation is due to serious issues like sexual misconduct, serious substance abuse, and repeated gross negligence.

One last outcome from this action: Julie Fellmeth commented in support of our petition but voiced concerns that probation orders are not being properly monitored and responses to probation violations are too slow and too mild. The board agreed to look into this matter, which we also think is very important.

Finally, I want to touch on the role of public members. An issue that was near and dear to Ben Shimberg. While certainly all board members should represent the public interest, public members have a super-responsibility to do so. Too often, the public members are indistinguishable from the physician members in their questions and their votes. And when they are not, they're always outnumbered. We want to see public members who are advocates for patients, just as physician members are advocates for doctors. You know what I'm talking about.

Recently the Federation of State Medical Boards issued a statement defining public members for its board but couched it in terms of what they should not be (e.g., a retired health care provider) rather than the attributes they are seeking in a person. Several years ago, we wrote California Governor Jerry

Brown encouraging him to appoint public members who have “demonstrated a historic commitment to working on behalf of consumers and who have no conflicts of interest.... Who should have a commitment to making the medical board transparent in its decision-making process and actions” and whose “backgrounds should reflect an unflagging commitment to the health and safety of health care consumers.”

Two patient safety advocates who we have worked with have been appointed to serve on state medical boards: Jean Rexford in Connecticut and Yanling Yu in Washington. These advocates were chosen because of their work on behalf of harmed patients. They are the type of public representatives we would like to see appointed to all occupational boards. The fact that you are here at this meeting indicates that you are serious about your public responsibilities. But there are many others who may never even think about it.

So, think about how you can take steps in every meeting to ask questions and pro-actively suggest changes that are specifically in the public’s interest. Even one provocative public interest question could make a significant difference. Ask for more transparency, more analysis of the boards’ work; give respect and attention to the few consumers and patients who make their way to your meetings; engage them in seeking solutions and suggest platforms where board members can get feedback directly from patients about their experience with the investigations of their complaints.

Thank you again to the Citizen Advocacy Center for all of the good work you do and for bestowing on me this recognition for the work that I love doing.

2016 – Kathleen Haley

As Executive Director of the Oregon Medical Board, for two decades of nurturing, supporting, and encouraging full and effective utilization of public members of the board.

Some song lyrics haunt us. Even years after we first hear them. Leon Russell’s “Tight Rope” 1970’s era lyrics have reverberated with me:

*I’m up on a tight wire,
One side’s ice and one is fire...
...I’m up on a tight rope,
One side’s faith and one is hope.*

Don’t those lines embody the role of the regulator? A constant balancing act. Before we enact rules, policy and position statements, we inch forward on the tight wire. Hoping the public and professionals we regulate are with us. Or that we can bring them along. All of us learning as we go.

Dr. Ben Shimberg, for whom this award is named, understood the need for fair and validated procedures to protect the public and the need to treat applicants and licensees equitably. A tall order. I am deeply honored to receive this award in his name.

While I remember Dr. Shimberg from CAC meetings, in preparing for this presentation I read more about him. He came from upstate New York, as did I and graduated from the University of Rochester like my mother and nephew. His research focused on tying our requirements for licensure to the safe practice of a profession.

Dr. Shimberg was instrumental in founding CLEAR and served as chair of the Board of Directors of CAC. How appropriate that both meetings are back to back here in Portland. I believe Ben would have been delighted.

In my remarks, I will discuss creative engagement and the necessity of mirroring what we expect of our licensees.

There is general lamentation about the erosion of the provider-patient relationship in favor of the bottom line. Any transition causes us to wring our hands. And we have been in transition in health care in the US for two decades.

What sets us apart as members and staff of health boards is that we are motivated by our missions. While the words may vary, the essence of public protection is omnipresent. Health regulatory boards have the benefit of not having to be influenced by financial gain. With that benefit comes the responsibility to oversee the professions, while engaging the other players and most importantly the public. The other players: health systems, practice groups, hospitals, insurers and professional associations sometimes operate in competitive silos.

Health regulatory boards, rather than being perceived as an integral part of the patient safety movement, may be thought of as the entity to avoid. I would maintain that we are the original patient safety organizations and that we have the facility to remain nimble.

One particular example of our flexing with the times is telehealth. Well over a decade ago, the Medical Board was approached by a hospital in rural Oregon that wanted to use a robot in the ICU. The robot or R2D2 would relay patient information to a physician specialist out of state. At the bedside of the patient was a licensed health care professional. The Board had a demonstration. And telemedicine licensure was well on its way.

Perched on that tight wire, let's hold our poles balancing faith and hope. Having strong, invested, well-trained public members is the first step. For decades, CAC has been my go-to organization for public member training, support and encouragement. I urge you to take a look at the recent newsletter, which has an excellent feature article by Becky LeBuhn on the role of the public member. Executives of all the health boards meet monthly. From Becky's piece, I am inspired to hold a meeting of all our public members.

Another thought raised in the piece is having our public members take the work of the boards to community groups. Do we do an adequate job of true public outreach? Our Web sites are the gateway for the public. They need to be as user-friendly as possible, relevant and current.

How easy is it for the public to call your board and talk with someone about their concerns? Is it like calling an airline? Yes, it costs more to have a person assist. It is a reminder of who we exist for.

While I recognize that resources are limited and quite frankly the professions often keep us dancing to their tunes, I challenge all of us to some meaningful public outreach. Not presentations to the professional organizations or schools but community organizations. Let's aim for a meeting with a public group once a quarter.

Because our roles are an amalgam of law, medicine and public policy we are drawn into politics. I have seen a number of colleagues removed because of a political issue, whether it be something as charged as abortion or someone's desire for perceived power. On that tight rope we inch forward, sometimes hesitating. Yet we must not retreat.

We communicate openly with fellow boards. One current example here in Oregon is need to a scope of practice issue. We regulate acupuncturists. There is a disagreement about whether "dry needling" is acupuncture. Physical therapists want to practice dry needling. My counterpart gave me a heads up that his board was asking for a legal opinion on the issue.

We need to cultivate relationships with legislators. Be the resource for health care issues in your state. We all certainly here from legislators when there is a disgruntled applicant or licensee.

Having those relationships can ease those struggles. We had a new one last week. A real estate agent emailed me regarding an applicant for licensure.

Funambulism is not for the faint of heart. It is thanks to the collective wisdom and courage of Board members, public and professional, who donate countless hours in service of patient safety that we remain inspired. That wobbly but perfect balance of faith and hope.

In Oregon, our mission, like yours, reflects the tension inherent in regulating professionals providing care in a complex, multi-faceted health care system. Balancing public protection while helping to ensure access to quality care. In a back room meeting with an educated rural legislator he confessed,

“I would rather have a bad doc than no physician at all.” Words borne of desperation and frustration. The fireside of that tight wire.

We maintain requirements for licensure, not wanting “bad providers,” but following Dr. Shimberg’s guidance we need to be able to demonstrate improvement in care as a result. We must acknowledge that there are many parts of the country where some care, even bad care feels better than none. We ignore those sentiments at our peril.

Following that meeting (and I would like to say we were ahead of the curve but not in that instance) we did a study of what documents took applicants the longest to obtain: medical school, residency and employment. We were able to address two of the three with expedite endorsement.

Continuous examination of our rules, processes and procedures for licensure and practice is essential. Weeding out those that are no longer necessary and updating with acknowledgement of the pervasive use of technology. For example, we recently implemented a secure portal for applicants to submit confidential information to licensing staff.

In interviewing some physicians under investigation, I have heard phrases such as, “that’s what the clinic required” or “that’s how the other physicians in the clinic practice.” Professional responsibility and board expectations did not enter into their thinking before poor practice. It is a mind-set that challenges us to educate and educate some more, our licensees. We need to annually visit the professional schools both to provide information and to learn what is on the minds of our new care providers.

An osteopathic student asked me last week if the board only acted punitively. I was able to tell him that sometimes the board required community service or to draft and teach a course involving their particular ethical transgression. It takes patience and fortitude to develop rules and creative solutions to thorny disciplinary issues. Our staff have sometimes spent years involving stakeholders in rule writing. The result is worth the effort. In particular, our rules on office based surgery.

I am deeply honored to receive the Benjamin Shimberg Award. It is as always a collaborative effort to walk the tight rope. We do it as a team. Each person on the board and each staff member has to be part of that effort. We offer staff members, regardless of whether they are in accounting or licensing, the opportunity to sit in on parts of our Board meeting. It is each person’s contribution that makes the Board successful. To witness the decision making process adds meaning to that contribution. In turn, it is helpful to the Board to get their perspectives.

Leon Russell’s lyrics go on (and here I take license):

“We’re united by life and the funeral pyre.”

How true. We all have the opportunity to be patients at some point in our lives. Collaborating across the silos can provide that safety net under the tight wire.

All of us need to assume the role of public members. And just as we hold our professions to a high standard, so too must we mirror those expectations: professionalism, competence, maintaining our personal health and the health of our organizations.

Special thanks to my inspired friends the Oregon Board and staff, and the CAC Board of Directors Becky LeBuhn, Barbara Safriet, Mark Yessian and Dave Swankin.

2017 – Council on Licensure, Enforcement and Regulation (CLEAR)

CLEAR is an association of individuals, agencies and organizations that comprise the international community of professional and occupational regulation. CLEAR is a dynamic forum for improving the quality and understanding of regulation in order to enhance public protection. Through conferences, services and publications, CLEAR provides the resources for ongoing and thorough communication of international licensure and regulation issues among all those interested in the field.

Shimberg Award accepted by Steve Hart, Executive Director, Kentucky Board of Pharmacy and President of CLEAR.

On behalf of CLEAR, thank you to David, Becky, and all at CAC for the great honor of receiving this award, given in the name of Dr. Ben Shimberg. Dr. Shimberg was instrumental in founding both of our organizations and dedicated much of his professional life to ensuring that the work of professional regulators focused - and indeed continues to focus - upon three things:

- 1) Ensuring that the public is protected from unscrupulous, incompetent and unethical practice;
- 2) Offering some assurance that those regulated are competent to practice in a safe and effective manner, and;
- 3) Providing for efficient disciplinary procedures where wrongdoing has occurred.

At a time when there is such considerable discussion about regulatory reform at the highest levels of state and federal government in the United States, almost all of which centers upon an economic perspective, Ben's clarity of thought and focus upon public protection is a timely – and timeless – reminder of what should be underpinning our discussions and every action we take as regulators. Little wonder that Dr. Shimberg was appointed an honorary CLEAR Board Member in June 2001.

Like CAC, CLEAR places its public protection role at the heart of all that it does. Part of CLEAR's mission is to serve as “a dynamic forum for improving the quality and understanding of regulation in order to enhance public protection.”

There are four distinct areas of substantive inquiry that CLEAR supports on an ongoing basis. In fact, its annual conference program is divided into four corresponding tracks: Compliance and Discipline; Testing and Examinations; Entry to Practice and Beyond; and Administration, Legislation and Policy. Approximately 100 committee members, drawn from CLEAR's broad membership, ensure the organization's resources meet the needs of professional and occupational regulators, and it is with them that this award is shared. Their extraordinary contribution and expertise ensures that all of CLEAR's output is created by regulators, for regulators.

It is the desire to improve the quality and understanding of regulation that has led CLEAR to focus so heavily upon its training and educational efforts, which have now involved more than 20,000 regulatory investigators and inspectors, and numerous regulatory leaders and board members. Recent additions to the stable of programming offered by the organization include a two-day course for those interested in Advanced Concepts in Regulatory Governance and a further two-day offering related to Administrative Law and the Regulatory Process. CLEAR continues to offer certified training for regulatory investigators and inspectors via its NCIT programming, Executive Leadership for Regulators for those in senior positions, and Introduction to Regulatory Governance, for Board and

Council Members. Recognizing that it is not always possible for Board and Council Members to attend in-person meetings, the Introduction to Regulatory Governance program is also offered via webinar, on-demand, and online. Given the important role that regulation plays in the life of our communities, it is imperative that those charged with administering, crafting, overseeing and ensuring compliance, are well-versed in best practices.

While there are certainly similarities between CLEAR and CAC, CLEAR has historically taken a markedly different path when it comes to adopting a formal position about a matter of controversy or interest. CLEAR has instead, quite deliberately, established itself as the forum in which a range of differing viewpoints can be discussed and explored¹. CLEAR is particularly well-placed to hear from a diverse range of stakeholders about the approaches they have taken, or those areas that may be of particular concern, given broad-based international involvement and members in North America, Europe, Asia and Australasia.

By looking broadly for, and at, regulatory innovation, CLEAR's stakeholders are exposed to the latest thinking in the sector. Recent areas of focus have included the role of risk, as it relates to regulators' role in protecting the public interest, safeguarding its welfare and preventing harm. A risk-based perspective on professional regulation has emerged over the past decade – most notably in the form of “Right-Touch Regulation” as espoused by the Professional Standards Authority in the United Kingdom—as a leading approach to dealing with the question of whether or not to regulate or to change the way regulation is enacted. A risk-based approach ensures that regulatory authority is applied only in proportion to the identified risk, and is mindful of the socio-economic realities within which the regulated profession operates. Risk-based regulation acknowledges the trade-offs a regulator faces in determining how best to protect the consumer. For example, a regulator may choose to focus resources on criminal background audits rather than continuing education audits.

The success of risk-based regulation is wholly dependent upon the proper identification, quantification and analysis of risks. Without this, any subsequent regulatory effort is doomed to failure. While the risk of public harm is of paramount concern, regulators also must consider the financial and reputational risks associated with the programs they plan to introduce and the actions they take – or choose to forego. In addressing risk issues, it is critical that the regulator identify and deal with the root causes and not be distracted by things that are merely symptoms of a greater underlying problem.

In addition, there is increasing interest in ensuring that regulators are seen to be more effectively engaged with, and more representative of, the wider community. To this end, CLEAR has recently offered sessions concerning Community Reference Groups (CRGs), which have been pioneered in Australia and Canada, among other jurisdictions.

Such groups can assist in designing outreach campaigns and with customer service initiatives, provide input into standards reviews, and feed into strategies that address critical issues of concern. Similarly, CRGs have also participated in responses to formal consultations initiated by governments.

CRGs have also provided regulators with additional expertise related to communication and messaging and improved the likelihood that outreach efforts will be successful. The groups also

¹ Editorial note from CAC: It is true that CAC occasionally takes a formal position on public policies (such as advocating for meaningful assurances of professionals' current competence rather than sole reliance on mandatory continuing education hours, removal of unjustifiable scope of practice restrictions facilitating the dissemination of telehealth services, etc...) CAC also prides itself as a “forum in which a range of differing viewpoints can be discussed and explored.”

provide regulators with access to the networks of individuals CRG members, which might not have otherwise been available to the regulator. Further, the groups have sometimes also offered a means by which critics of a regulator can be meaningfully engaged and brought into the regulatory process.

As we look forward, CLEAR will continue to focus on the role technology plays, and will play, in ensuring regulation is both effective and efficient. We are particularly interested in learning more about Blockchain Technology and the future role it might play in the field, particularly in light of the work that has been undertaken in financial regulation.

As efforts continue to explore regulatory reform, CLEAR is pleased to have a seat on the Expert Panel of the National Conference of State Legislators (NCSL)-led Occupational Licensing Project. The project, which also involves the National Governors Association (NGA) and the Council of State Governments (CSG) focuses on the effect occupational licensing has on several populations: skilled immigrants; people with criminal records; active duty military and veterans and their spouses; and unemployed and/or dislocated workers. CLEAR looks forward to engaging further with this diverse group and to serving as a resource, as needed, for the potential reform efforts that will be undertaken by the eleven participating states.

As regulators we seldom receive recognition – other than critical headlines – and so CAC’s decision to recognize CLEAR’s work is particularly appreciated and welcome. CLEAR looks forward to continuing its quest to promote regulatory excellence and deeply appreciates the encouragement receiving the Ben Shimberg Public Service Award provides.

2018 – Denise Roosendaal

For recognizing the important roles public members play in accomplishing the goals of occupational and professional credentialing, and for committing ICE resources to help public members achieve peak effectiveness.

Thank you, Becky. I am grateful and humbled to accept the Ben Shimberg award. The list of past recipients contains some of my professional heroes and I hardly feel worthy of such distinguished recognition. I did not know Mr. Shimberg but I have crossed paths with many who did. I've heard numerous accounts of his passion, his intellect, and his approach to life, and these remembrances make this award even more meaningful.

In 2011, just a few months after assuming the Executive Director role at Institute for Credentialing Excellence (ICE), Becky LeBuhn appeared in my office with a copy of Mr. Shimberg's book, Occupational Licensing: A Public Perspective. With her hands on her hips-- in that simultaneously sweet and commanding way that is completely Becky-- she said, "If you know what's good for you, you'll read this." Over the years, I may have overdramatized that memory but I am certain I accurately recall her respect and admiration for this man and his work. I did read that book and I continue to keep it within easy reach in my office.

Shortly thereafter, David Swankin and I began our tradition of having breakfast in DuPont Circle. He taught me so much about public members and licensure ... and fighting for what's right. I knew I was learning from a great mind and from a man with incredible experience. So I listened. Plus, we've had a lot of fun.

I've had the privilege of working alongside so many wise and passionate leaders in my career. But what I have learned about the importance of public member service I have learned from these two powerhouse individuals, the "dynamic duo," as I refer to them. And I would like to publicly thank them for their contributions to this cause. They have guided me and believed in me over the past seven years. You are both role models to this community and to me. Thank you for your service.

It's nice to be in a room with individuals who understand what I do and why I do it. For as long as I've been married (eleven years now), I've tried to explain my job to my mother-in-law. I throw around words like "credentialing" and "competencies." I talk about the importance of regulation, enforcement of standards and public protection. I opine about scope of practice and psychometrics. She finally confessed that it would be easier to tell people that I work for the CIA!

I am proud to lead an organization like ICE that recognizes the value of the role of the public member. ICE has a public member on each of our governing bodies – the board of directors, the NCCA Commission and the newly established Accreditation Services Council. ICE also supports public members by offering them complimentary registration to our annual conference when the Executive Director of their organization also attends. We have established the Public Member Working Group, led by Becky LeBuhn, that reaches out to public members and develops valuable services to support their efforts. Becky is also highlighting the role and importance of public members through a series of interviews in the ICE Credentialing Insights online journal. We are collecting data on the current public members in our community and plan to collect information on prospective public members, as well. It is my vision that ICE will become a conduit for connecting those willing to serve with those organizations that need public members.

I wish I could stand here today and say our work in protecting the public is done. But we are far from done. With legislative threats at the state level, we must stand guard and challenge efforts that could damage consumer protection and patient safety. Our work is not done. As I ponder the North Carolina Dental Board Supreme Court case, I see that our work is not done. When misunderstanding of maintenance of certification is written into licensure law or hospital credentialing practices, it is clear that our work is not done.

I'm not a pessimist ... and I'm not an alarmist ... and I'm not opposed to common sense reform. I'm always seeking ways to move forward and create a better tomorrow. But I am concerned.

I'm also curious. I'd like to know who is now in possession of the crystal ball. Apparently, some in this room have had access to a crystal ball over the years, because they have predicted a future that, in some ways, is now coming true.

Allow me to share two specific examples of what I mean.

In 2012, David brought me a copy of an article from the New York Times about hair-braiding licensure. He said, "This is going to be a problem." The hair-braiding example has been raised in more credentialing meetings I've attended in the past year than any other. It seems to be the fuel for those seeking drastic restrictions on occupational licensure.

The second example is from, Paul Grace, a two-time past president of ICE. In his lecture for the Ben Shimberg award in 2012, he said, "If the public and private entities that make up this industry are to be successful in their public service mission, the number one need is focused, informed, and courageous leadership."

I couldn't agree more. With these two wise predictions in mind, I'd like to engage in a few predictions myself.

The first has to do with recent legislative activities. Legislative conversations and inquiries about occupational reform will continue and will require more outcome measures. Since that hair-braiding article, we've seen a dozen states consider or enact some kind of occupational licensure reform with varying degrees of success. I'm not necessarily critical of reform. It's always a good idea in the name of public protection and even economic progress to examine the impact of regulation. These conversations **should** attempt to find that balance between the public's and the occupation's best interest; the balance between economic health and public protection; the balance between barriers to entry (perceived or real) and the need for qualified workers. I say **should**, because sometimes finding that balance is nowhere in the conversation. Well, until we remind them, of course!

The occupational reform legislation we saw this past year had continual problems with ill-defined terminology, which led to confusion for the lawmakers. The Louisiana legislation originally included language that would have prohibited the use of the term "certified" unless the individual was also licensed. This would have wiped out the ability of individuals with voluntary certifications from being recognized in that state. After the bill was appropriately amended, one of the sponsoring legislators confessed to not understanding the impact of the language.

ICE is now part of a coalition, the Professional Certification Coalition (PCC), which is a joint partnership between ICE and the American Society of Association Executives. This coalition is

comprised of 100 professional societies and credentialing organizations with a mutual goal of monitoring and amending, when necessary, various state legislative attempts to reform occupational licensing. We are not debating the reform initiatives on the merit of the intent.

Rather, we are monitoring the proposed legislation to determine whether they contain damaging misunderstandings or misinterpretations of how certification works, or onerous evidentiary requirements for sunrise or sunset review of licensure, or if those reviews appropriately balance economic concerns with public safety or consumer protection.

ICE is part of another coalition: The Right to Safe Care Coalition (RTSCC). This group of associations and credentialing bodies is addressing the proliferation of limitations or outright prohibitions on mandatory demonstration of continued competence. This coalition is focusing on educating the public about the importance of continuing competence requirements.

These initiatives have resulted in conversations about the role and importance of credentialing, public safety and consumer protection, and the recognition of competence. However, while there is good research available, the highest goal of preventing harm to the public can be difficult to quantify. How do you prove that injury did not happen as a result of an individual being regulated or certified?

ICE now has a research agenda for the next several years, and we will be reaching out to universities, third-party research entities and other professional organizations to assist. Many fine organizations have engaged in dynamic research endeavors, too. But we must become more focused in sharing this information more widely with external audiences.

Now, let's move on to governance. *My prediction is that governance models will need to continue to evolve in the future.* I teach a governance workshop for our non-profit staff and I have to admit that governance is not a sexy topic. It's a bit difficult to get entry-level associates excited about the topic even when I tell them that governance is where the magic happens. But I do see a glimmer in their eyes when I tell them how amazing it is when a group of volunteers from all walks of life come together with a serious focus on protecting the public or shaping a profession or creating change or enabling a vision of the future.

In the shadow of the North Carolina Dental Board decision, we are starting to see some legislative attempts to address concerns about governance. Some are tackling it from the anti-trust aspect; others are addressing representation-related issues.

At a recent CLEAR conference, the Council on Licensure, Enforcement and Regulation, I learned of three independent Canadian studies about the state of licensure (McMaster Health Forum report; CNO Vision 20/20; PSA Review). Several common themes are clear. More public representation on professional licensing bodies is needed; some studies recommend as much as 50% public representation. There is a call for more training for public members. Also advisable are fewer popularly elected or politically connected board members and more member selections based on merit and experience.

While figuring out new governance models can feel a bit mundane, when it's structured well and focuses on what's important, governance need not be an obstacle but source of empowerment and innovation.

Finally, let's look at changing demographics. My prediction is that understanding the needs of consumers, patients and the future workforce will become even more relevant and challenging. The Millennials are not coming – they're here. This next gen professional is speaking loudly as a consumer and as a member of the workforce. You've heard this before, I'm certain. With an expectation to change careers – not just jobs, but careers – six times in their lifetime, the next gen professional is thinking carefully about ROI. If they graduated college with enormous debt, they are rightfully wondering whether the time and expense needed to be invested in a credential will pay off in the estimated 7.5 years they'll be engaged in that profession before moving on to the next.

In the workplace, the question has focused on whether or not this generation is adequately prepared for work. This next generation has already changed how universities and professional associations approach education and continued professional development. These future professionals are not expecting recognition or advancement without the learning as some have cynically suggested. But they are demanding to understand how their learning connects with how they will advance in their field. This generation has always had wide and deep access to technology and they will not settle for cookie-cutter approaches to the delivery of education.

The eligibility requirements for certification bodies will also need to reflect those various demands and new perspectives.

The good news? As consumers and citizens, this generation is demanding transparency from government, their employers, and those in positions of authority. I think they would make great public members. I just learned last week of a certification body that intentionally sought out a millennial as their public member for all the reasons I just stated.

Perhaps the most disconcerting of the millennial trends is the threat on established knowledge as expressed in the book "Death of Expertise" by Tom Nichols. This book outlines how society now values the opinion of reviewers over traditionally demonstrated expertise. This is the Yelp generation. In addition, with the amount of information at our fingertips and the trend to self-inform or self-diagnose, the means to evaluating the value of a product or program or a professional is now turned upside down.

Despite all of these changes and challenges, I am encouraged by what is ahead of us. I am encouraged by the conversations we're having with various stakeholders. I am encouraged by the continued dedication of the professionals and volunteers in the credentialing community. I am encouraged by you and your dedication to this field.

In the introduction of Mr. Shimberg's book, he states, "The air is filled with charges and countercharge about who benefits the most from licensing..." Benjamin Shimberg, *Occupational Licensing: A Public Perspective* (Princeton: Educational Testing Service, 1982).

That was 1982. I believe it is equally true today. Finding the right balance for the highest public benefit is critical.

The next time I talk with my mother-in-law about my field of work I'm simply going to tell her that I help protect the public by making sure that professionals have demonstrated they know what they're doing.

You all know the important role of public members for public protection. But you are the choir. So, I say to you today, Choir, sing. Sing loudly and sing powerfully and sing outside these walls to the many stakeholders who have not yet heard your song about protecting the public. Stay vigilant, stay focused, stay centered on the importance of public members and in this crazy political and regulatory environment we find ourselves in, I say “sing on and lead on.”

I thank you again, for this distinguished honor. Mr. Shimberg continues to cast a long and powerful shadow in the credentialing community and I pledge to work hard to honor his legacy.

Thank you.

2019 – Zeno St. Cyr

For his many years of service as an articulate and effective public member on health professional licensing boards and voluntary credentialing organizations, Zeno St. Cyr personifies Ben Shimberg's aspirations for public representation.

Thank you, Dr. Shampaine, for your gracious introduction. I first met Guy during my early years of service on several state, regional, and national Dental boards. Since that time, I've looked to Dr. Shampaine as a colleague and mentor on the important patient protection mission of these licensing and credentialing organizations. More valued, however, is his friendship over the years since we met.

I also want to thank the Board of the Citizen Advocacy Center for its selection of me as this year's recipient of the Shimberg Public Service Award. I was quite taken aback and totally surprised when David called to inform me of my selection for this prestigious award. I was humbled by the news then and remain so today.

I would be remiss if I neglected to mention my enduring admiration of the work performed by the CAC, which is ably led by David Swankin and Becky LeBuhn, two individuals who continue to amaze me as founts of knowledge about issues, organizations, and people within the sphere of licensing and credentialing.

Past recipients of the award have distinguished themselves in the public service arena, including the very first recipient, Dr. Mark Yessian, who also serves on the CAC Board of Directors and is my former colleague. Many years ago, Dr. Yessian and I both worked in the U.S. Department of Health and Human Services Office of Inspector General. Mark, you've left some considerably large footsteps in which to follow.

The theme for this year's meeting, Healthcare Regulation and Credentialing in an Anti-Regulatory Environment, is both timely and relevant. Throughout our nation, legislation is being introduced in state legislatures and federal policies are being considered that could fundamentally change the current credentialing environment. During the course of this conference, you will learn more about what is happening around the country and what is being done to address current and planned efforts.

So rather than address these matters, my remarks today are focused on Public Service and the important role that public servants play in protecting the public.

Public Service Is Critical for Public Protection

The Humorist, Mark Twain, said Public Servants are "persons chosen by the people to distribute the graft." Those of us in this room could probably tell Mr. Twain a thing or two about personal enrichment or the enrichment of others through Public Service...or not!

Another view on public service is found in words by our nation's 44th President, Barack Hussein Obama, who said, and I quote, "That's when America soars, when we look out for one another and we take care of each other, when we root for one another's success, when we strive to do better and to be better than the generation that came before us and try to build something better for generations to come, that's why we do what we do. That's the whole point of public service."

In truth, public service most often goes unrecognized and unappreciated, but for the many dedicated public servants who provide this public benefit, public service is its own reward.

My experiences on many licensing and credentialing boards, coupled with my life-long work as a Public Health professional, have equipped me with a keen sense of the value of licensing and credentialing and the importance work of public servants in assuring public protections in health care.

Patient safety should always remain foremost in any discussion of licensing or credentialing policies, standards, and criteria. Whether current or former members of State Boards, credentialing organizations, health professionals, academic institutions, health professional associations, or other health professions communities of interest, we must be united in insisting that public protection guide any decisions made with regard to clinical licensing and credentialing, as well as adverse actions or disciplinary decisions undertaken or considered.

This importance cannot be minimized because the public depends on academic institutions, credentialing organizations, ultimately government -- and by extension State regulatory boards and credentialing organizations -- to assure that any individual that graduates from an accredited institution, passes a requisite credentialing examination, and subsequently is licensed to practice in a health profession has sufficiently demonstrated the minimal, critical competencies necessary to practice.

The Public's View

In truth, the public is clueless about the credentialing process. The public does not know about the independent testing community, including whom they are or what they do. Some in the public may know that an examination is given to candidates for credentialing, but most have no idea whom administers that test nor what competencies are actually tested.

Most of the public are not interested in what school or even what country a health professional was trained. But the public does want assurances that when they sit in a dental operator, their problem will be appropriately addressed; when examined by a medical professional, the proper diagnosis will be made; or when filing a prescription, the correct name brand or generic medication will be dispensed, in the appropriate dosage, and with the proper instructions for taking it.

Public Protection Mission

For the last seven or eight years, I've had the privilege of participating in the Maryland Health Department's orientation program for new Health Occupations Board members. In my presentation, I discuss the important public protection role that each will play on his or her respective board.

I stress that as Public Servants, our public protection mission is often a juggling act. Unlike a court of law, our work is conducted behind closed doors, out of view of the public. Particularly with regard to disciplinary or adverse licensing decisions, we must appropriately balance public protection and the practitioner's professional reputation. This means gathering all the relevant facts and weighing all mitigating and aggravating factors before acting in the best interest of the public...not the individual being examined.

Equally or perhaps even more important, as Public Servants we must recognize that a failure to act can have devastating consequences. As an example, I cite the tragic New England Compound Center (NECC) incident.

In October of 2012, the Massachusetts Department of Public Health began an inspection of NECC, a compounding pharmacy, after the company's tainted steroids were linked to meningitis and other infections that sickened nearly 800 people in more than 20 States across the U.S. and is now been blamed for more than 100 deaths.

Almost immediately, questions were raised about why the Massachusetts pharmacy board did not take stronger action against NECC, despite having investigated 12 complaints about the company's practices over a decade and receiving a 2003 warning from the Food and Drug Administration (FDA) that the pharmacy's practices could cause "serious public health consequences" and should be curtailed.

The Boston Globe reported that one of the individuals appointed to the 11- member Massachusetts Board of Registration in Pharmacy in 2004 and reappointed in 2008 also served as the vice president of regulatory affairs and compliance at another pharmacy owned by the same individuals who owned NECC, raising serious conflict of interest questions.

In the resulting fallout, the Massachusetts' pharmacy board's Director was fired and its board attorney was placed on leave. Several NECC officials were convicted of criminal offenses and sentenced to jail, including one individual who was apprehended at the airport while attempting to flee the country. Several NECC Pharmacists were criminally convicted for filling obviously phony prescriptions for patients such as Coco Puff, LL Bean, and Mary Lamb.

In January 2013, Massachusetts finished conducting 40 unannounced inspections of different compounding pharmacies; only four passed; all or part of 11 of those pharmacies were shut down.

In other collateral action, because the FDA lacked authority to regulate or conduct inspections of compounding pharmacies whose product is shipped in interstate commerce, on November 27, 2013, the Drug Quality and Security Act (HR. 3204) was signed into law by President Obama. The new federal legislation grants the FDA more authority to regulate and monitor the manufacturing of compounding drugs, a task which previously was the sole responsibility of state pharmacy boards.

As further evidence of the important role of licensing and credentialing public servants in protecting the public, several years ago, Johns Hopkins analyzed health data over an eight-year period and found that more than 250,000 Americans die each year because of medical errors, making medical errors the third leading cause of death behind heart disease and cancer.

Conclusion

Public service is vitally important and public servants have a fiduciary responsibility to protect the public by making sure that all candidates awarded a license or a credential demonstrate critical competency in all required skill sets.

Further, requisite continuing education and periodic clinical assessment through recertification assures a certain standard of qualifications for the workforce and fosters currency on the latest

medical knowledge. Currency is important since, according to one study, medical knowledge has doubled every 3.5 years since 2010 and could double every 73 days by 2020!

As policy-makers continue to struggle to find ways to provide adequate healthcare for its citizens...for example, when considering nascent policies, regulations, or legislation to address the myriad issues related to telehealth/telemedicine or contentious scope of practice issues...as public servants we must ensure that any solutions considered or implemented have public protection at the centerpiece.

In closing, I leave you to ponder the words of Margaret Chase Smith - the first woman to serve in both chambers of the United States Congress, and the first woman to represent Maine in either. Senator Chase Smith also was the first woman to be placed in nomination for the presidency at a major party's convention, in 1964.

“My creed is that public service must be more than doing a job efficiently and honestly. It must be a complete dedication to the people and to the nation with full recognition that every human being is entitled to courtesy and consideration, that constructive criticism is not only to be expected but sought, that smears are not only to be expected but fought, that honor is to be earned, not bought.”

My heartfelt thanks to the CAC for this prestigious award. I will cherish it and endeavor to continue to earn the honor by trying my best to live up to the beliefs espoused by Dr. Shimberg, the tenets represented by this award named in his honor, and the example set by the many distinguished past honorees.

Thank you for your attentiveness this afternoon. Continue doing the good work that you do in your home communities.

Enjoy the remainder of this wonderful conference.

2020 – Cynthia Miller Murphy

For her public service in multiple leadership positions within the Institute for Credentialing Excellence (ICE) and for promoting and supporting public membership at all levels of ICE.

Healthcare Certification in the Balance

Thank you, Becky. I am so honored to receive this award and indeed humbled to be among so many deserving recipients who have been outstanding leaders and advocates for public protection. I did not know Ben Shimberg personally, but his leadership in competency assurance and regulation had a tremendous influence on me and my work in nursing certification. I am especially grateful to Citizen Advocacy Center (CAC) leaders, David Swankin and Becky LeBuhn for their important work in advocating for public representation on health credentialing boards. I was lucky enough to meet them early in my credentialing career and I have learned a great deal from them. I also want to thank Denise Roosendaal and the Institute for Credentialing Excellence (ICE) for including this lecture in the ICE Town Hall this year.

As previous recipients of this award have noted, it was somewhat challenging to prepare this lecture, primarily because the direction from Becky was simply to think about what I'd like to say and to review the lectures of the previous recipients. I have to say, reviewing the past lectures was an informative, enlightening and quite humbling experience- not to mention a little intimidating!

As I considered what to talk about today, I looked back on the 30 years I worked in nursing certification and considered the future of healthcare credentialing. Two areas that I believe are vital to certification serving the public interest in the future came to mind: certification board composition and the assurance of continuing competence. Board composition came to mind because historically, certification boards have been very homogeneous and most do not adequately reflect the breadth of their stakeholders.

Continuing competence came to mind because historically certification bodies have devoted far more resources to initial certification than ongoing maintenance of certification. Although there has been some progress in recent years, I believe most certifying boards still have a great deal of work to do to strike a better balance in these areas. Keep in mind that balance does not mean that all elements are always in equal amounts, but rather in proper or appropriate amounts for that particular point in time.

Balancing Board Composition

All certification programs have a rich diversity of stakeholders; however most governing boards do not adequately reflect this diversity. Board composition is a key element of governance and good governance is essential to an organization reliably carrying out its purpose. Something I always found extremely important and sometimes challenging in nursing certification was striking the appropriate balance between the dual purposes of public protection and advancement of the profession. This duality of interests sets certification apart from licensure. The purpose of licensure, like many other regulations, is primarily for public protection and safety. Whereas specialty certification has the additional purpose of promoting the development of specialty areas of the profession. For many occupations, specialty certification is thought to raise the level of professionalism. Historically, specialty certification boards were established because professionals wanted an avenue for recognition of their expertise. When oncology nursing certification was established in the mid 1980s, it was because nurses wanted a means to formally recognize their

professional expertise in oncology and hence advance the professionalism of the specialty. Oncology nurses solicited the professional association to establish the specialty certification.

Patients were not lobbying for a means to ensure oncology nurses were competent to provide safe care in the specialty. This is most likely because patients did not, and unfortunately, for the most part, still do not understand the difference between licensure and a specialty certification. Nevertheless, over the past century, hundreds of specialty healthcare certifications have been established, mostly at the behest of the professionals themselves. This may be the reason that so many healthcare certification boards are heavily composed of certified professionals, with little representation of other stakeholders. As these organizations strive to strike the appropriate balance between public protection and recognition of the specialty, balancing board composition is vital.

Good governance, which is essential for all organizations is directly influenced by the individuals that make up the board of directors. Those individuals are responsible for determining strategic direction, setting policy, providing oversight, monitoring performance and ensuring accountability. It's vitally important to have the right mix of talent, skills and abilities on the board and to ensure that there is a balance of stakeholder representation. Boards that are rich in diversity of perspective will ultimately make better decisions and ensure that the organization continues to evolve.

Healthcare certification boards have made some progress in recent years, but most are still homogenous. The National Commission for Certifying Agencies Standards require that accredited organizations ensure stakeholder representation and include at least one member, with voting rights, that represents the public or non-employer consumer interest on the board. It is up to the organization to define its stakeholders and based on the composition of many certification boards, it seems the only stakeholders are certificants and the obligatory one representative of the public. If we were to truly strike a balance between the dual purposes of public protection and advancement of the profession, might we need to fill half the seats on our boards with consumer members? Perhaps not, in consideration of the breadth of other stakeholder groups; but in most cases, I propose that just one representative of the public among a board heavily weighted with certificants, is not well balanced.

As for other stakeholders, boards need to carefully define these, thinking well beyond the various credentials offered by the organization and consider ways they might include representation to bring their board composition into better balance. This will change over time, depending on the shifting environment and it is important to stay flexible and responsive. In healthcare certification, stakeholders are abundant and may be specialty-specific. A good place to start is with the healthcare team. Very few healthcare professionals work alone. Care is provided by a team and all members of the team hold a stake in the other members' performance. Hence including other members of the healthcare team is a good strategy to expand the diversity of a board. The National Board for Certification and Recertification of Nurse Anesthetists (NBCRNA) provides a great example. This board currently includes an anesthesiologist and a surgeon- professionals who work closely with and depend upon nurse anesthetists. Similarly, many of the specialty certification boards for physicians now include nurses or pharmacists. Others stakeholders to consider include academic and continuing education providers, third-party payers and administrators.

The set of stakeholders for each organization is broad and unique and the balance will change over time as factors in the environment change. As noted above, balance does not mean absolute equal representation of each stakeholder interest, but rather appropriate representation for the time. I

believe most board members do well in defining their unique set of stakeholders, but may have difficulty believing that board members outside of their certification constituency would be capable of defining strategy and policy for their organizations. Certification boards may also be challenged to venture out of their typical networks to recruit candidates. However, to ensure balanced stakeholder input and diversity of thought, boards need to develop sound strategies for the recruitment of members outside of their constituency, including sources for the recruitment of consumer and public members. The recently formed ICE Diversity, Equity and Inclusion Task Force supports this goal.

Boards members must also be cognizant that they share responsibility for the success of each member. They must develop adequate screening mechanisms to ensure candidates have the requisite skills and abilities needed to serve. This does not mean that candidates know everything about the organization. They may actually know very little about the organization. It means they have had previous experiences that illustrate their skills in critical and strategic thinking, teamwork, communication, oversight, seeing the big picture and whatever else is important for a specific board. It is up to the board to provide comprehensive on-boarding, orientation and ongoing education for all members of the board to optimize performance. This includes customized education to assist individual board members to meet their learning needs with regard to their role on the board, regardless of the stakeholder interests they represent. Efforts to recruit the right individuals representing a diversity of stakeholders and providing the right support and education for board members will strongly influence and enhance board performance. Once those members are on the board, it is important to ensure they have full board responsibilities and serve on key committees such as the Discipline and Governance Committees.

Balancing the Culture to Emphasize Ongoing Competence

As boards have become somewhat more diverse over the past few decades, there has also been progress, albeit slow, in the assurance of ongoing competence by certification boards. Historically, credentialing boards have focused more resources on initial certification, most often through multiple choice examinations. The emphasis for boards and certification candidates has been on developing and passing the initial examination to earn the credential. While this may have been sufficient at one time, the exponential turn-over of medical knowledge in the past decade has illustrated the critical importance of current and ongoing knowledge for all healthcare providers.

When I first began my career in nursing certification more than 30 years ago, physician certification boards had no requirements for recertification. At the time, my organization, the Oncology Nursing Certification Corporation (ONCC), required nurses to retake and pass the examination every four years to maintain certification. This drew much ire from oncology nurses, most especially because the oncologists with whom they worked had no requirements for certification maintenance. It was a one-and-done deal for the physicians. Managing our certificants' angry rants expressed in letters, on the phone and in-person during conferences helped me to develop new skills in diplomacy. Nonetheless, I was very relieved when the Medical Oncology Board of the American Board of Internal Medicine established Maintenance of Certification Requirements in the 1990s. But, even then, the majority of oncologists were grandfathered since the new requirements affected only those earning new certificates.

All of the medical specialty boards, as well as a few other innovative organizations have made good progress in recent years. However, we still have a long way to go to foster a culture wherein the meaning of certification is one of ongoing improvement and lifelong learning, rather than

episodically meeting requirements at specified intervals. For certification to serve the public interest, it can no longer be a “one and done” or even a “one and done every several years” approach. Certification must represent a progressive process that demonstrates a certificant’s current and ongoing competence. This has become especially critical as the rate of knowledge acquisition required for competence in healthcare has grown exponentially. In 1950, it took about 50 years for the total of medical research to double. That accelerated to seven years in 1980, three and a half years by 2010 and was projected to be only 73 days by 2020. (<https://www.elsevier.com/connect/the-dynamism-of-clinical-knowledge> Accessed November 16, 2021). This rapid acceleration of knowledge growth has negated the value of our summative evaluation approaches to certification. In 1950 it was probably adequate to certify healthcare providers for life. And, even in 2010, it may have been fine to assume a certificant’s competence for four or five years after they passed the certification examination. Our current environment requires a much different approach to ensuring continuing competence among certified healthcare professionals.

If new approaches to the assurance of ongoing competence are to be effective, there must first be a culture change fostered by organizations and adopted by certificants. This change requires a shift away from the episodic, summative approach toward a more ongoing and formative approach that is engaging, encourages continual learning and provides feedback. The standard approach to recertification, wherein candidates pass an examination and then complete a set of requirements at predetermined intervals encourages a “binging” approach to simply “jump the hoop” rather than encouraging the continual and deliberate attainment of new knowledge that is meaningful to each certificant’s individual practice. Many healthcare certifications still rely on a standard number of self-selected continuing education hours for recertification despite evidence that individuals are generally not good at judging their own competence or determining their own learning needs. This is especially true of the least competent professionals.

Additionally, there is little evidence to support continuing education as a means to ensure competency. In my experience, due to the nature of this requirement, many certificants simply choose continuing education that is convenient for them to attain, rather than what they may actually need. In addition, most continuing education does not require the completion of any type of assessment to demonstrate that learning actually occurred. This approach also limits interaction between the certificant and the certifying body, further perpetuating the episodic nature and disengagement of certificants.

Making changes to recertification requirements has indeed proven to be challenging for many certifying boards and these challenges have been exacerbated in the midst of a recent rise in anti-regulatory attitudes. There has been strong push-back from certificants, law suites and even legislation opposing continuing competency programs. Nevertheless, several organizations have prevailed and it is gratifying to see that organizations are investing resources into developing innovative approaches to support ongoing competence, life-long learning and certificant engagement.

Some of the biggest strides have been among member boards of the American Board of Medical Specialties (ABMS). The new ABMS requirements for continuing certification emphasize life-long learning and ongoing professional development. Medical specialty boards have developed a variety of innovative approaches, such as quarterly online formative assessments that provide feedback

and can be chosen in place of a high stakes summative assessment. This evolution has been 30 years in the making, but is quite an improvement over lifetime certification.

A few nursing certification boards have also taken steps toward better ensuring ongoing competence and engagement of certificants. NBCRNA is in the process of phasing-in a new comprehensive approach to certification maintenance consisting of four core requirements. This approach includes attainment of continuing education that requires completion of a post-test, professional activities such as teaching, publishing and research, low stakes assessment to identify individual learning needs that must be followed with educational activities to meet those needs, and completion of educational modules in four core areas focused on the most current, evidence-based information. The Pediatric Nurses Certification Board is one of the few organizations that requires certificants to complete continuing competency requirements every year. Pediatric certified nurses have several options of requirements to choose from each year, within a seven-year cycle, thus keeping certificants engaged and supporting a culture of continual learning. ONCC and the National Certification Corporation require certificants to complete a low stakes assessment to identify individual learning followed by completion of a variety of educational activities to meet those needs.

These are all steps toward a culture change that will better serve the public interest. The time has come for all certification boards to think strategically about their recertification programs, allocate significant resources and take steps toward more efficacious requirements. Changing culture can be a daunting task, but as several organizations have demonstrated, it is possible, given sufficient determination, resources and time. Though more research is needed to determine the efficacy of various methods for recertification, it is clear that it is time to move beyond the typical requirement of the accumulation of continuing education hours. At a minimum, acceptable continuing education should include a measure of quality, such as accreditation and an assessment of learning such as a post-test. The recertification process should begin as soon as a credential is earned and must involve an ongoing portfolio approach with options to choose from, frequent touch points, formative assessments, and feedback. Requirements should be grounded in practice and directly linked to individual learning needs. Due to the dynamic nature of current healthcare, professionals regularly take part in point of care learning by engaging in self-directed, online learning on topics relevant to their clinical practice. Incorporating this practice into recertification requirements will be beneficial to consumers and certificants.

Organizations should be prepared for push-back from the constituency when making changes. To quote Frederick Douglass “If there is no struggle, there is no progress.” A change in culture involves changing attitudes and behaviors. This is rarely easy for any group and in this case emotions may be quite high. Certificants may fear losing a credential that is required for their ongoing employment. To ease the burden for certificants, new requirements can be phased in over time. However, each organization should have a clear predetermined timeline for implementation. The value of clear, ongoing communication should not be underestimated. Organizations should use every opportunity and avenue available to educate the constituency about new expectations.

As certification organizations take steps toward new and improved programs for ensuring ongoing competency, it is important to keep in mind that these certification organizations are not solely responsible for this task. In addition to the certifying body, many entities share responsibility for ensuring that healthcare professionals remain competent to practice safely. The public would benefit from better coordination among these entities. The 2010 Institute of Medicine report entitled *The Future of Nursing: Leading Change, Advancing Health* made the recommendation that “accrediting bodies, schools of nursing, health care organizations, and continuing competency educators from multiple health professions should collaborate to ensure that nurses and nursing students and faculty continue their education and engage in lifelong learning to gain the competencies needed to provide care for diverse populations across the lifespan.” (Institute of Medicine (US) Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine. *The Future of Nursing: Leading Change, Advancing Health*. Washington (DC): National Academies Press (US); 2011. PMID: 24983041.) I would like to see academic institutions, employers, professional associations, continuing education providers, licensing boards and certification boards across disciplines use standardized approaches to establish competencies and document professionals’ attainment and maintenance of those competencies. There should be ease of communication among these entities and a coordinated systemic approach, with each entity fulfilling its part to ensure safe and competent healthcare is provided.

Keep Moving to Find Balance

In closing, I’d like to return to the concept of balance and something I learned when I was seven years old. At the time, I was happily riding my 20-inch powder blue Schwinn equipped with training wheels. But then one day, some nasty boys started taunting me for having training wheels. So, I went home, took the training wheels off all by myself and ventured back out into the neighborhood with my bike. After a few tumbles into hedges and some scraped knees and elbows, I got the hang of it and realized that in order to keep my balance, I had to keep moving. The training wheels were quite comfortable, but as long as I had them, I wasn’t going to learn anything new or make any progress. I encourage all healthcare certification boards to take off the training wheels to make progress toward better serving the public interest. Venture beyond your certifiants to include diverse perspectives on your boards and create a culture that provides appropriate emphasis on ongoing competence. It might be wobbly at first but if you keep moving, you’ll find your balance.