## California

### California Regulatory Groups Consider Reclassification to Recognize Podiatrists as Physicians

The California Medical Association (CMA), the California Orthopaedic Association (COA) and the California Podiatric Medical Association (CPMA) have announced a joint task force to review the education, curriculum and training of California's podiatric medical schools with the ultimate goal of accrediting them as full-fledged allopathic medical schools.

It is the first agreement of its kind anywhere in the nation, according to the CMA.

The joint task force will examine current podiatric medical school standards and curriculum in the state, hoping to create podiatric training programs that are equivalent to that of medical school for physicians and surgeons. The goal, according to CMA, is to prepare podiatric students "to be licensed as physicians and surgeons in California and provide patients in California with the highest quality of care."

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The task force was created with the expectation that the California podiatric medical schools will be be accredited by the Liaison Committee on Medical Education (LCME), a nationally recognized accrediting authority for medical education programs leading to the M.D. degree in U.S. and Canadian medical schools.

"Throughout this process, CPMA has made the strong case that the education and training of doctors of podiatric medicine have evolved and become increasingly similar to that of medical doctors," said CPMA Executive Director Jon Hultman.

"We're excited to be a part of this unprecedented partnership," said CMA Chief Executive Officer Dustin Corcoran. "The licensure requirements of podiatrists have increased in California in recent years, and the time has come to evaluate their training programs in this context. The California Medical Association is looking forward to working with the COA and the CPMA to fully evaluate the education and training of podiatrists to identify and remove any remaining deficiencies so that future podiatric medical graduates would simply be medical school graduates." ■

Source: California Medical Association website, June 2011

## Iowa

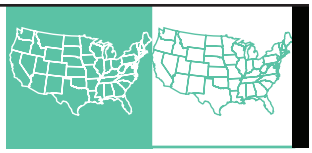
### Iowa Board of Medicine Celebrates 125th Anniversary

The Iowa Board of Medicine plans to observe its 125th anniversary this year with two special events, starting with a public meeting and reception July 29, 2011 in Iowa's "Old Capitol," located in Iowa City. The Board will convene in the Senate chamber of Old Capitol at 9:30 a.m. for a meeting to conduct routine work, with a reception to follow at 11 a.m.

An open house will be held on the afternoon of September 22, 2011, in the Board's office in Des Moines.

The State Board of Medical Examiners was established on July 1, 1886, to license and regulate physicians. In 1994, the Board assumed responsibility for registering acupuncturists, and subsequently the licensure and regulation of acupuncturists in 2000 when the law was changed. In 2007, the board's name was changed to the Iowa Board of Medicine. ■

Source: Iowa Board of Medicine website, June 2011



## Maine

### Maine Prescription Monitoring Program Managed by New Vendor

The prescription monitoring program (PMP) for the State of Maine is now hosted by a new vendor, Health Information Designs, Inc. (HID). Physicians already authorized to access Maine's PMP database who visit the database online are being notified of the changeover and given instructions for accessing and logging on to the new PMP.

The Maine Board of Licensure in Medicine reports that diversion of prescription opiates is a serious and growing problem in the state. Data from the State Medical Examiner's office indicates that accidental overdose due to opiates has been rising in recent years and that nearly all accidental deaths (94 percent) are caused by at least one prescription drug.

To help physicians who are asked to undertake the difficult task of managing pain while recognizing addiction and preventing diversion, the Maine Office of Substance Abuse (OSA) offers two types of free reports through its PMP database. Solicited reports are provided when a registered clinician queries the database online to obtain an immediate report on all Schedule II, III and IV prescription medications dispensed to a patient and how the patient paid for these medications. Unsolicited "threshold" reports are sent to physicians who have prescribed for a patient whose profile exceeds threshold indicators that suggest a possible problem with prescription medications. The threshold reports are generated quarterly.

To learn more about Maine's PMP, visit www.hidinc.com/mainepmp. ■

Source: Maine Board of Licensure in Medicine website, June 2011

## North Carolina

### NCMB Launches Task Force to Evaluate Its Position on Self-Treatment

The North Carolina Medical Board (NCMB) has established a task force to revisit the Board's position statement on the issue of treating self, close family members and other loved ones. The effort will include a public meeting at NCMB's offices in Raleigh to discuss the position statement and consider possible changes.

North Carolina's current position statement, titled "Self-treatment and the treatment of family members and others with whom significant emotional relationships exist," was adopted in May 1991. It was subsequently updated in 1996, 2000, 2002 and 2005. The position cautions against self-treatment and the treatment of loved ones, except for minor, acute illnesses or in emergency situations.

> '...PHYSICIANS SHOULD NOT TREAT, MEDICALLY OR SURGICALLY, OR PRESCRIBE FOR THEMSELVES, THEIR FAMILY MEMBERS, OR OTHERS WITH WHOM THEY HAVE SIGNIFICANT EMOTIONAL RELATIONSHIPS.'

The board launched the task force after finding that "many licensees are unaware of the position statement and others find it vague and confusing."

The current position statement offers this guidance for North Carolina physicians:

"It is the position of the North Carolina Medical Board that, except for minor illnesses and emergencies, physicians should not treat, medically or surgically, or prescribe for themselves, their family members, or others with whom they have significant emotional relationships. The Board strongly believes that such treatment and prescribing

practices are inappropriate and may result in less than optimal care being provided. A variety of factors, including personal feelings and attitudes that will inevitably affect judgment, will compromise the objectivity of the physician and make the delivery of sound medical care problematic in such situations, while real patient autonomy and informed consent may be sacrificed."

"When a minor illness or emergency requires self-treatment or treatment of a family member or other person with whom the physician has a significant emotional relationship, the physician must prepare and keep a proper written record of that treatment, including but not limited to prescriptions written and the medical indications for them. Recordkeeping is too frequently neglected when physicians manage such cases."

"The Board expects physicians to delegate the medical and surgical care of themselves, their families and those with whom they have significant emotional relationships to one or more of their colleagues in order to ensure appropriate and objective care is provided and to avoid misunderstandings related to their prescribing practices." ■

Source: North Carolina Medical Board website, June 2011

## NCMB Adopts Rules for Physician Reentry

The North Carolina Medical Board has adopted administrative rules that set out its expectations for licensees who wish to resume practice.

In North Carolina, a physician or physician assistant must complete a program of reentry if he or she is applying for a license to practice in the state and has not actively practiced or "has not maintained continued competency, as determined by the board, for the two-year period immediately preceding the filing of an application." The board states that the "purpose of such a program is to demonstrate that the applicant is competent in his or her intended area of practice."

The board adopted a position statement on reentry in 2006 titled "Competence and reentry to the active practice of medicine," which states the board's expectation for reentry candidates to develop a satisfactory reentry program.

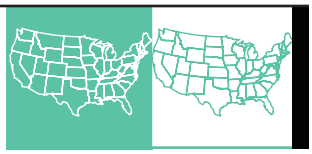
The state's reentry rules standardize the board's reentry program by listing specific factors that affect the terms of an individual's reentry program.

THE STATE'S REENTRY RULES STANDARDIZE THE BOARD'S REENTRY PROGRAM BY LISTING SPECIFIC FACTORS THAT AFFECT THE TERMS OF AN INDIVIDUAL'S REENTRY PROGRAM.

These factors include the length of time out of practice, the prior intensity of practice, the skills needed for the intended area of practice, the reason for the interruption in practice and the licensee's activities during the interruption in practice, including the amount of practice-relevant CME completed.

The rules also define a reentry program as consisting of a multi-phase period of mentoring under a physician approved by the board. Phases of the program include an observation phase, during which the reentry candidate observes his or her mentor in practice; a phase during which the reentry candidate practices under their mentor's direct supervision; and a final phase during which the reentry candidate practices under the mentor's indirect supervision. ■

Source: North Carolina Medical Board Newsletter: 2011, No. 1



## Oregon

### Oregon Welcomes New Medical School — Second in the State

The first class of students will begin studies soon at Oregon's newest medical school — Western University's College of Osteopathic Medicine of the Pacific (COMP) Northwest. The new program is the first medical school to open in Oregon in 100 years. The other is at the University of Oregon.

The campus, located in Lebanon, Oregon, will open in August 2011 with a class of 100 students scheduled to graduate in 2015. According to the Oregon Medical Board (OMB), entrance into the class has been competitive, with more than 2,500 applications.

At full capacity, the school will serve 400 students, most of whom will be from the Pacific Northwest. Graduates will complete residencies and begin entering the workforce as early as 2018.

COMP began in Pomona, California, in 1977 and is expanding into Oregon with its new Northwest campus. The new school will occupy a 54,000 square foot building, where it will stream online lectures and provide interface with students and faculty at the Pomona campus. ■

Source: Oregon Medical Board *Report*, Spring 2011

## Texas

### Texas Effort to Crackdown on Illegal Pain Clinics Continues

The Texas Medical Board (TMB) reports that it has suspended or cancelled the certifications of eleven pain clinics, while taking action against scores of individuals for pain medication-related violations, as it continues its sweeping initiative to curb so-called "pill mills" in the state.

In a high-profile arrest this spring, the Drug Enforcement Agency (DEA) apprehended Houston physician Gerald Ratinov, M.D., and 18 other co-conspirators. According to the DEA, Dr. Ratinov was the most frequent prescriber of hydrocodone in the state.

Texas lawmakers adopted a bill in 2010 that significantly strengthened regulation of pain clinics, including a stipulation that pain clinics must be owned and operated by Texas-licensed physicians, who must register with the TMB. Pain clinic ownership certificates are not transferable or assignable.

The bill also tightened up background requirements of the owners of pain clinics, including a provision that owners must not have been subject to disciplinary action by any licensing entity for conduct that was a result of inappropriately prescribing, dispensing, supplying or selling a controlled substance. Under the bill, medical directors of pain clinics must ensure on an annual basis that their personnel are properly licensed and are trained in pain management. ■

Source: Texas Medical Board *Bulletin,* May 2011 and Spring 2010

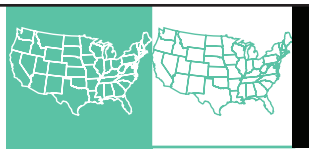
### Sheriff Convicted in Medical Whistleblower Case in Texas

Sheriff Robert L. Roberts Jr. of Winkler County, Texas, has been convicted of taking retaliatory actions against two nurses who complained to the Texas Medical Board (TMB) about a physician who is a friend of his.

Jurors returned guilty verdicts on four felony counts and two misdemeanor charges.

Anne Mitchell and Vickilyn Galle had reported the physician they worked for, Rolando Arafiles, Jr., MD, to TMB, accusing him of using herbal remedies and inappropriate use of hospital supplies.

Their letter was unsigned, but when Dr. Arafiles found out about it, he asked Roberts to investigate, saying he was being harassed. The women were



later fired from the hospital and charged with felonies for misuse of official information. One of the two was acquitted and charges against the other were dropped.

Later, they sued the county, the hospital, Roberts and others, charging that their prosecutions had been vindictive, and won a $750,000 settlement. In February, TMB placed Dr. Arafiles on probation for four years.

Sheriff Roberts was fired as a result of the convictions. He was sentenced to 100 days in jail, four years of probation and was fined $6,000.

"The verdict sends a message that nurses, patients and family members can bring a complaint about a doctor to the Texas Medical Board without fear of retaliation," TMB Executive Director Mari Robinson told the Associated Press.

Health care associations across the nation had watched the case closely and publicly commented on it, saying it was a key test of physician accountability and that it had the potential to put a chilling effect on nurses and others who wanted to report unethical or illegal activity in the workplace. ■

Source: Associated Press, June 14, 2011

## Virginia

### Requests for Data Using Virginia Prescription Monitoring Program Up Dramatically in Last Two Years

The Virginia Board of Medicine reports that requests for reports through the Virginia Prescription Monitoring Program (PMP) have grown from 75,000 in 2009 to more than 433,000 requests in 2010. Prescribers and pharmacists account for 98 percent of all requests to the program, according to the board. The program anticipates processing more than 600,000 requests in 2011.

According to the board's website, "abuse and diversion remain realities in the Commonwealth, and deaths from prescription drugs continue at an alarming rate."

Prescribers in Virginia are encouraged to use the Prescription Monitoring Program to access information about patients for whom they prescribe or anticipate prescribing Schedule II-IV controlled substances. Patient consent is no longer required to access this data in Virginia; however, patients must be informed that a provider might check their data.

Virginia's PMP was upgraded in 2009 to provide round-the-clock access with auto-response software. According to the board, the number of prescribers registered to use the program has more than doubled since the installation of the new software two years ago.

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Approximately 1,900 resident pharmacies, non-resident pharmacies and dispensing physicians submit prescription records for Schedule II-IV drugs each month in Virginia. The program database holds more than 60 million prescriptions, which supply the data for almost 2,000 daily reports in response to requests from 7,600 prescribers and 1,600 pharmacists who use the information to make treatment and dispensing decisions.

To learn more, visit www.dhp.virginia.gov/medicine. ■

Source: Virginia Board of Medicine website, June 2011