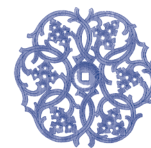

CALIFORNIA

INVESTIGATING PHYSICIANS SUSPECTED OF SUFFERING FROM DISABLING MENTAL AND PHYSICAL CONDITIONS

Business and Professions Code section 821.5 became law on Jan. 1, 1997. The law addresses concerns regarding timeliness of hospital medical staffs completing investigations and corrective action regarding physicians with potential impairment affecting competency, thus putting patients at risk. Medical staff can initiate a "formal investigation" of a physician when there are concerns the physician may be suffering from a disabling mental or physical condition that threatens patient care. The law still allows medical staff to investigate physicians with suspected impairment without automatically referring the case to the board, as long as the physician cooperates with the investigation and the investigation is completed in a timely fashion.

Under 821.5, such formal investigations require completing the steps of the investigation in accordance with specified timelines. California Code of Regulations, Title 16, sections 1362-1362.1, contains the time for investigations and the contents of the required report. Within 15 days of initiating a formal investigation, a "peer review body," as defined in B&P Code section 805, must report the action to the board's diversion program administrator.

The medical staff must gather facts within 30 days. Within 45 days, the medical staff must evaluate and dispose of the matter. (For an outside evaluation, 75 days are allowed.) A final report must be rendered to the diversion program administrator within 15 days of disposition of the matter. Disposition of the case can involve the following determinations and actions:

- No problem exists.
- List problems and indicate mental or physical disorder diagnosis, if applicable.
- If a mental or physical disorder exists, is there a threat to patient care? If yes, explain.
- Indicate implementation of applicable "action plan" options:
  1) Treatment for the disorder.
  2) Monitoring of the physician and description of the monitoring plan.
  3) Practice restrictions or conditions that have been summarily imposed.
  4) Practice restrictions or conditions have been recommended and the physician has been offered a hearing under B&P Code section 809.1.
  5) An 805 report has been filed.
  6) Other.

The board has developed peer review body forms for the initial report and for the final report. These forms are available and will be presented in a frequently asked questions format in the next issue of the board newsletter *Action Report* in January 2005.

CALIFORNIA MANDATES UNIVERSAL SCREENING OF THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) FOR PREGNANT WOMEN

Women, particularly women of color, are the fastest growing population with AIDS both in the United States and in California.* Even more alarming, the percentage of annually reported female AIDS cases in California has risen every year since 1983. As such, in October 2003, former Governor Gray Davis signed Assembly Bill 1676 into law (Health and Safety (H&S) Code sections 125085, 125090, 125107 and 125092).

The H&S Code requires routine incorporation of HIV testing into the standard battery of prenatal tests as a strategy to ensure that all women have the opportunity to be prenatally tested for HIV, when interventions to prevent transmission to the unborn baby are most effective. The Centers for Disease Control and Prevention (CDC) has recommended offering prenatal HIV testing for all pregnant women since 1995. Routine testing is a strategy to help ensure pregnant women are tested for HIV, particularly women who do not know they are at risk of contracting HIV. This strategy should reduce treatment costs through the earlier identification of infected mothers and the prevention of HIV transmission to their infants.

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H&S Code sections 125085, 125090, 125107 and 125092 require medical care providers to screen every pregnant woman in the state for HIV as part of the standard prenatal test panel. Additionally, providers are required to explain the purpose of the HIV test and to ensure the right of the woman to refuse the test. The statute also requires laboratories to report a positive HIV test result to their local health office and requires the provider who ordered the test to inform the woman of the test results.

Under H&S Code sections 125085, 125090, 125107 and 125092, HIV testing would not be required if the pregnant woman has been previously determined to be infected with HIV.

By Jan. 1, 2005, HIV informational material and a consent form can be downloaded via the Internet by accessing PDF files in English, Spanish, Armenian, Cambodian, Farsi, Korean, Lao, Chinese, Hmong, Russian and Vietnamese at DHS/OA's website at http://www.dhs.ca.gov/AIDS.

More information on the state statute described above is accessible through the Internet on the official California legislative information website at www.leginfo.ca.gov. HIV care and treatment information for health care providers is available through the Warmline at (800) 933-3413.

HIV referral and consultation resources for patients, including experts of prenatal HIV treatment, are available through the California HIV/AIDS Hotline at (800) 367-2437 (AIDS).

*Centers for Disease Control and Prevention. *HIV/AIDS Among U.S. Women: Minority and Young Women at Continuing Risk.* http://www.cdc.gov/hiv/pubs/facts/women.htm.

LEGISLATIVE UPDATE

The following legislation, which may impact physicians licensed in California, has been chaptered into law and took effect Jan. 1, 2005 (bills with an urgency clause take effect upon enactment). For additional information on all of these bills, please contact the website maintained by the Legislative Counsel of California at www.leginfo.ca.gov (click on "Bill Information").

Medical Care, Licensing and Enforcement

AB 30 (Richman, Chapter 573) Permits licensed health care facilities to print prescription forms by computerized prescription generation systems and exempts these forms from specified recordkeeping requirements. Provides that these computer-generated forms may contain the prescriber's name, category of professional licensure, license number, federal controlled substance registration number, and the date of the prescription. Deletes the inclusion of a pharmacy prescription number, license number, and federal controlled substance registration number from the prescriber's duty to keep a record of Schedule II and, as of Jan. 1, 2005, Schedule II and Schedule III prescriptions dispensed by the prescriber. Contains an urgency provision and went into effect on Sept. 18, 2004.

AB 691 (Daucher, Chapter 36) Requires specified nursing facilities to offer immunizations for influenza and pneumococcal disease to residents 65 years or older. Residents must first have their eligibility for the immunization determined by their physician or the medical director. Requires the facilities to obtain informed consent from residents prior to the administration of the immunizations.

AB 1403 (Nunez, Chapter 367) Renames the California Physician Corps Loan Repayment Program of 2002 to the Steve M. Thompson Physician Corps Loan Repayment Program.

AB 1629 (Frommer, Chapter 875) Requires skilled nursing facilities to include in a resident's care assessment, the resident's projected length of stay, and discharge potential. Requires the attending physician to indicate in the assessment the needed care to assist the resident in achieving his or her preference of a return to the community. Requires the Department of Health Services to develop and implement a facility-specific rate-setting system subject to federal approval. Contains an urgency provision and went into effect on Sept. 29, 2004.

AB 1975 (Bermudez, Chapter 756) Clarifies provisions of last year's AB 236, Bermudez (Chapter 348, Statutes of 2003). Requires the board to revoke the license of any person subject to the requirement to register with the police as a sex offender on or after Jan. 1, 1947. Contains provisions authorizing a one-time petition to the Superior Court for reinstatement of a license, if revoked after Jan. 1, 1947 and prior to Jan.1, 2005. Provides an exemption for a physician who is required to register as a sex offender solely because of a misdemeanor conviction under Penal Code section 314 or whose duty to register has been formally terminated under California law.

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AB 2049 (Nakanishi, Chapter 78) Requires a person or facility that offers fetal ultrasound, for entertainment or keepsake purposes, to make the following specified written disclosure to the client prior to performing the ultrasound: "The federal Food and Drug Administration has determined that the use of medical ultrasound equipment for other than medical purposes, or without a physician's prescription, is an unapproved use." The disclosure must state that the use of ultrasound equipment without a physician's prescription is unapproved by the federal Food and Drug Administration (FDA).

AB 2185 (Frommer, Chapter 711) Requires health care service plans to provide coverage for equipment used in the treatment of pediatric asthma.

AB 2626 (Plescia, Chapter 452) Eliminates the requirement for a supervising physician to countersign a patient chart when a Schedule III, IV, or V drug order is administered by a physician assistant. The supervising physician still is required to review and countersign the chart when the physician assistant is issuing a Schedule II drug.

AB 2835 (Plescia, Chapter 452) Provides that it is a cause for revocation or suspension of a health care license or certificate for a health care professional to solicit, accept, or refer any person to a health care practitioner with the knowledge that, or with reckless disregard for whether, the individual intends to commit insurance or workers compensation fraud.

AB 3023 (Matthews, Chapter 351) Requires the board, along with other healing arts practitioner boards, to report within 10 working days to the Department of Health Services, the name and license number of a person whose license has been revoked, suspended, surrendered, made inactive by the licensee, or placed in another category that prohibits the licensee from practicing his or her profession.

AB 3044 (Yee, Chapter 770) Requires, with specified exceptions, sonographers who perform prenatal ultrasounds to screen for congenital heart disease to substantiate that they meet specified training and experience levels. Requires a sonographer, screening for congenital heart disease, to perform ultrasounds under the supervision of a physician. Becomes effective on July 1, 2006.

SB 136 (Figueroa, Chapter 909) Corrects an unintended consequence from the board-sponsored licensing status change from last year's SB 1077 (Chapter 607, Statutes of 2003). Due to this change, some physicians were required to change their licensing status from retired to active to continue practicing in the same manner they had practiced prior to the status change. The law still requires that the licensing status change take place, but requires payment of fees, as a result of these changes, only when the change in status coincides with the physician's renewal date. Requires the board to refund the money it already has collected from physicians who were forced to change their licensing status outside of their normal two-year renewal cycle. The time period set forth for this change to occur to receive this benefit was Jan. 1, 2004, through Dec. 31, 2004. Extends the due date of the enforcement monitor's initial report to the Legislature from Sept. 1, 2004, to Nov. 1, 2004, and extends the due date of the final report from Sept. 1, 2005, to Nov. 1, 2005. Clarifies that it does not constitute a waiver of any exemption from disclosure or discovery or of any confidentiality protection or privilege otherwise provided by law when the board provides confidential data, information, or case files to the enforcement monitor.

SB 1159 (Vasconcellos, Chapter 608) Establishes the Disease Prevention Demonstration Project (DPDP) to evaluate the long-term desirability of allowing licensed pharmacists to furnish or sell nonprescription hypodermic needles or syringes to prevent the spread of blood-borne pathogens. Permits a physician or pharmacist, without a prescription or permit, to furnish hypodermic needles or syringes for human use if the person is known to the furnisher and the furnisher has previously been provided a prescription or other proof of a legitimate medical need requiring a hypodermic needle or syringe to administer a medicine or treatment. Permits, between Jan. 1, 2005, and Dec. 31, 2010, a pharmacist to furnish or sell 10 or fewer hypodermic needles or syringes to a person 18 years of age or older, if the pharmacist works for a pharmacy that is registered for the DPDP. Permits the legal possession of 10 or fewer hypodermic needles or syringes if acquired through an authorized source from Jan. 1, 2005, to Dec. 31, 2010.

SB 1691 (Vasconcellos, Chapter 742) Excludes a physician from being subject to disciplinary action for certain aspects of unprofessional conduct solely on the basis that the treatment or advice he or she rendered to a patient is alternative or complementary medicine, if the treatment meets all of the following requirements:

- It is provided after informed consent and a good faith

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prior examination of the patient.
- It is provided after the physician has given the patient information concerning conventional treatment and described the physician's qualifications related to alternative or complementary medicine.
- It does not cause a delay in, or discourage, the traditional diagnosis of a condition of the patient.
- It does not cause death or serious bodily injury to the patient.

SB 1725 (Knight, Chapter 404) Updates and makes clarifying and conforming changes to the provisions relating to parking placards and license plates for the disabled. Requires the physician, chiropractor, or optometrist who signs a certificate for a placard to retain information sufficient to substantiate that certificate. (Language also found in AB 1138 Frommer, Chapter 363)

SB 1782 (Aanestad, Chapter 864) States the intent of the Legislature that the California District Attorneys Association (CDAA), on or before Jan. 1, 2006, collaborate with interested parties, including the Medical Board, to develop protocols for the development and implementation of interagency investigations in connection with a physician's prescription of medication to patients. The protocols shall be designed to facilitate a timely return of all seized medical records.

SB 1794 (Perata, Chapter 486) Establishes standards for administering antipsychotic medication to persons found incompetent to stand trial (IST). Requires psychiatrists or psychologists appointed to examine potential IST defendants to also evaluate whether medication is medically appropriate and likely to restore mental competence.

SB 1913 (Business and Professions Committee, Chapter 695) Allows a retired physician to continue to use the title "Doctor" or the designation "M.D." Provides the specified liability protection to a medical expert who reports to any part of the medical board. Allows student midwives the same opportunities afforded other health professionals by permitting matriculating students the opportunity to provide clinical services.

Other Health Professionals

AB 932 (Koretz, Chapter 88) Clarifies the scope of practice for doctors of podiatric medicine, clearly authorizing them to perform limited amputations and to treat ulcers or wounds of the lower leg that are related to a condition of the foot or ankle. Clarifies that amputations cannot be of the entire foot. Requires the Board of Podiatric Medicine, in consultation with the Office of Examination Resources of the Department of Consumer Affairs, to ensure that Part III of podiatric examination adequately evaluates the full scope of practice for podiatric medicine. Changes "podiatrist" to "doctor of podiatric medicine."

AB 2560 (Montanez, Chapter 205) Removes the restrictions on nurse practitioners as to the health care settings and areas in which they may furnish or order drugs or devices for patients in accordance with standardized procedures or protocols, developed by the nurse practitioner and the supervising physician. Permits nurse practitioners to furnish or order drugs and devices whenever it is consistent with their educational preparation or for which clinical competency has been established and maintained.

AB 2660 (Leno, Chapter 191) Reinstates a pharmacist's authority to register with the U.S. Drug Enforcement Administration (DEA) as a mid-level practitioner and therefore initiate or adjust controlled substance drug therapy under physician protocols.

SB 1485 (Burton, Chapter 117) Clarifies physical therapists' scope of practice and revises the definition of physical therapy to include "the promotion and maintenance of physical fitness to enhance the bodily movement related to the health and wellness of individuals through the use of physical therapy intervention." Eliminates the requirement for a physician referral and allows physical therapists direct access to healthy individuals.

SB 1633 (Figueroa, Chapter 861) Prohibits any business from seeking to obtain medical information directly from an individual for direct marketing purposes without clearly and conspicuously disclosing how it will use and share that information and obtaining the consumer's consent to that use and sharing. Exempts businesses that are already subject to the Confidentiality of Medical Information Act, certain telephone corporations, and insurance institutions, agents, and support organizations, as specified.

SB 1765 (Sher, Chapter 927) Requires pharmaceutical companies to adopt and update a Comprehensive Compliance Program (CCP) that is in accordance with the April 2003 publication "Compliance Program Guidance for Pharmaceutical Manufacturers," which was developed by the U.S. Department of Health and Human Services' Office of Inspector General. Requires pharmaceutical companies to establish explicitly in their

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CCP an annual dollar limit on gifts, promotional materials or other items or activities, with exceptions, in accordance with existing guidelines, as specified.

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OHIO

BOARD UPDATES MASSAGE THERAPY SCOPE OF PRACTICE

After nearly six years of work, the board has officially updated the massage therapy scope of practice, rule 4731-1-05 of the Administrative Code. It is important to note the new rule is not meant in any way to expand the massage therapy scope of practice, but rather serves to clarify the long-standing components of the massage therapy scope of practice. Highlights of the changes include the following:

- Throughout the rule, references to "massage" have been updated to "massage therapy" to be consistent with previous changes in statute.
- In paragraph (A), addition of the phrase "manipulation of soft tissue" and removal of the term "passive" from "joint movements." Additional language has also been added to paragraphs (F)(3), (F)(4) and (F)(5) to clearly identify the parameters of the LMT practice, limiting joint manipulations to those consistent with LMT education and training. Paragraph (F)(3) specifically includes a reference to the prohibition on LMTs performing chiropractic, but the board did not intend by only listing chiropractic to in any way suggest or authorize massage therapists to perform physical therapy or any other profession not specifically enumerated in the rule.
- In paragraph (B), inclusion of clarification that a massage therapist may educate patients consistent with their evaluation of the patient. MTAC indicated that such advice to patients, within the scope of practice, is clinically valuable but that practitioners had been deterred because of uncertainty regarding their authority.
- New paragraph (C) explicitly protects the title and designation "Massage Therapist" and "LMT," to assist in differentiating limited branch practitioners from other purveyors of massage.
- New paragraph (E) protects the public by requiring display of the certificate to practice.

The newly amended rule became effective May 31, 2004.

COMPASSIONATE CARE TASK FORCE ISSUES REPORT

The Compassionate Care Task Force report addresses issues surrounding the care and treatment of patients suffering from terminal illness or severe chronic pain.

Recognizing the importance of addressing the profound physical, psychosocial, and economic impacts of terminal illness and severe chronic pain, the Ohio General Assembly enacted House Bill 474 in December 2002, creating the Compassionate Care Task Force. The task force met monthly from May 2003 through March 2004 for the purpose of studying and making recommendations concerning issues surrounding the treatment and care of persons with terminal illness or severe chronic pain. These recommendations are discussed in a new report from the task force, which can be found currently on the board's website under "Medical Alerts" at http://www.med.ohio.gov. The task force will continue to meet through March 2005 to address its second responsibility of monitoring and reporting on the implementation of its recommendations.

H.B. 474 delineated a variety of participants for the task force (including 18 physicians) and required the director of health or the director's designee to be the group chairperson. Task force members include board Vice President Patricia Davidson, M.D., board Executive Director Tom Dilling and board Assistant Executive Director William Schmidt. Mr. Dilling and Mr. Schmidt have also served on the Ohio Pain Advisory Committee to the director of health since its inception.

The task force activities began with identification of the many barriers interfering with appropriate care of persons with chronic pain and persons with terminal illness.

Following identification of barriers, three subcommittees worked to (1) identify current needs and resources for pain management and palliative care in Ohio, (2) identify best practices for the care of persons with chronic pain, persons with terminal illnesses, and the family members of these two groups of patients, and (3) develop strategies to improve the pain management and palliative care practices in Ohio.

Some of the barriers to quality of care of persons with chronic pain and persons with terminal illness that served as the framework and rationale for the task force recommendations included:

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- Health care professionals receive insufficient education on the care of persons with pain and persons with terminal illnesses in their basic education programs; many practicing health care providers have not updated their knowledge and skills in these areas; and, there is a lack of pain and palliative care specialists throughout the state, but especially in rural areas;
- Fear and misunderstanding of the existing statutes and rules regarding prescribing of opioid medications interfere with appropriate pain and symptom management; and
- Fear of regulatory scrutiny and litigation interfere with providing appropriate care.

Education and understanding are two significant ways to conquer fear. The medical board encourages licensees to visit its website and read the report of the Ohio Compassionate Care Task Force, as well as the board's rules in Chapter 4731-21 of the Ohio Administrative Code (OAC) on prescribing for intractable pain. The hallmarks of the board's rules are that physicians who prescribe to a patient with a terminal condition are not subject to disciplinary action by the board if the treatment is provided pursuant to the requirements of Ohio Revised Code (ORC) Section 2133.11; physicians who treat intractable pain by utilizing prescription drugs, including opiates and other controlled substances, are not subject to disciplinary action by the board if the treatment is provided in accordance with ORC Section 4731.052 and the rules found in OAC Chapter 4731-21; and there is a recognition that physical dependence and tolerance are normal physiological consequences of extended opioid therapy, and do not, in the absence of other indicators of drug abuse or addiction, require reduction or cessation of opioid therapy. If you read these statutes and rules, you should understand they are based on sound principles and standards of medical practice that are essential for the safe and competent treatment of pain.

In addition, the board encourages those physicians who encounter patients with intractable pain in the usual course of their practices to complete continuing medical education related to the treatment of intractable pain, including coursework related to pharmacology, alternative methods of pain management and treatment, and addiction medicine. Accepted standards of care in medical practice require the adequate treatment of pain. The board urges you to consider assessing pain as the fifth vital sign in your own practice.

Reprinted from the Summer/Fall 2004 issue of the *Your Report*, published by the State Medical Board of Ohio.

VIRGINIA
NEW LAWS FROM THE 2004 SESSION OF THE GENERAL ASSEMBLY

The following legislation affecting the professions regulated by the board is now in effect. Included are the links to the text of each bill should you wish to read it in its entirety.

HB 211
Historically, the board had two committees to help it investigate and audit the practices of its licensees. With the advent of centralized investigations and inspections by the Enforcement Division of the Department of Health Professions and the use of expert reviewers, the committees were utilized less frequently. As part of Governor Warner's initiative to streamline government by abolishing boards, commissions, committees, etc. that added little to the mission of an agency, these two committees, the Medical Complaint Investigative Committee and the Medical Practice Audit Committee, were abolished by this legislation.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0040

HB 309
This legislation makes it unlawful to practice occupational therapy without a license. It also requires individuals who practice as occupational therapy assistants to obtain certification from a credentialing organization approved by the board. The bill provided for emergency regulations, which have been promulgated and are in effect.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0061

HB 319
This legislation provides for extensions of professional licenses for citizens of Virginia serving outside of Virginia or the United States in the armed forces or in the diplomatic corps.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0975

HB 409
This legislation authorizes podiatrists to perform amputations proximal to the metatarsal-phalangeal joints in a

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hospital or ambulatory surgery center that is properly accredited.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0731

HB 577
The central feature of this legislation is the newly granted authority for the board, and other boards, to delegate some informal fact-finding proceedings to "agency subordinates." An agency subordinate could be a single board member, board staff, or other qualified individual. The board has already promulgated emergency regulations and addressed how it intends to use this newfound authority.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0064

HB 633
The Virginia Board of Nursing participates in the Nurse Licensure Compact, which allows nurses from other states that participate in the compact, to practice in Virginia without obtaining a Virginia license. This legislation clarifies the regulatory authority the Virginia Board of Nursing has over individuals who are practicing here with multistate privilege under the compact.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0049

HB 733
This legislation authorizes a patient's executor or administrator to obtain copies of the patient's health care records in pursuit of litigation. Currently only the patient, his attorney or an insurer can obtain the records.
http://leg1.state.va.us/cgi-bin/legp504.exe?ses=041&typ=bil&val=hb733

HB 851
This legislation continues collaborative agreements between pharmacists and doctors of medicine, osteopathy or podiatry.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0853

HB 855
This legislation authorizes nurse practitioners to sign a plethora of forms, essentially all those that call for the signature of a physician. Please read the entire bill for details. This bill called for emergency regulations (see below) and stated that the regulations on this matter should include that the authority for a nurse practitioner to sign forms be included in the protocol with the collaborating physician.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0855

HB 856
This legislation requires that each person licensed to practice optometry in the Commonwealth after June 30, 2004 be qualified for prescribing Therapeutic Pharmaceutical Agents. An optometrist's prescriptive authority is expanded to include Schedule III through VI controlled substances and devices. Emergency regulations to address the Schedule III through VI drugs appopos for treatment of the eye and its adnexa are under development. For information, contact the Board of Optometry.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0744

HB 875
This legislation requires upon closure, sale or relocation of a practice, current patients of the practice will be notified of the change and the option of obtaining records. For the purpose of this law, current patient means one who has had an encounter in the previous two years. Relocation is defined as moving more than 30 miles away.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0053

HB 877
This legislation raises the bar for denying a patient access to his/her records. The test will now be that there is the likelihood that release of records to the patient will endanger the life or physical safety of the patient or another individual, or that a reference to another person in the medical record might cause substantial harm if the records are released. The patient can engage a physician or clinical psychologist to review the records, and the decision regarding release by the reviewer must be followed.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0065

HB 878
This legislation brings Virginia law into compliance with HIPAA while providing access to health records and information for guardians ad litem and attorneys representing minors in juvenile and domestic proceedings, proceedings to authorize treatment for patients incapable of providing treatment, persons who are subject to petitions for involuntary commitment, and those for whom a petition seeks appointment of a guardian or conservator.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0066

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HB 879
This legislation synchronizes Virginia law regarding medical records privacy and HIPAA.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0067

HB 1133
This legislation clarifies the physician or nurse midwife assuming care of a newborn infant has the responsibility for performing screening tests for inborn errors of metabolism, not the delivering physician or midwife.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0760

SB 159
Athletic trainers have been certified by the board. Pursuant to this legislation, they will be licensed.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0669

SB 160
This legislation clarifies the doctor-patient relationship created by an emergency room visit or on-call duty terminates upon discharge from the Emergency Department or the hospital unless the doctor and patient affirm they wish to continue the relationship. This termination does not relieve the physician from the duty to follow through with checking and communicating pending test results, or any other aspect of care that would be deemed integral to the standard of care for the patient and the condition.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0878

SB 224
This legislation lifts restrictions on physicians that may have prevented them from fully disclosing to patients all medical treatment options. It also prohibits health insurers from placing such limitations on physicians. Physicians who disclose such information have immunity from liability to any health insurer.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0675

SB 337
This legislation synchronizes Virginia law with HIPAA, modifies the procedure by which a patient can receive records that, in the judgment of the practitioner, should be withheld and addresses access to health records for guardians ad litem and attorneys. This bill is similar to HBs 877, 878 and 879.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP1014

SB 385
This legislation further defines the communications protected under privileged, confidential peer review processes.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0250

SB 498
As a result of this legislation, podiatrists are able to list any specialty board certification awarded by the American Board of Multiple Specialties in Podiatry. This board offers specialty certificates in primary care in podiatric medicine, podiatric surgery and prevention and treatment of diabetic foot wounds.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0703

SB 555
This legislation authorizes a physician assistant (PA) practicing under the supervision of a physician to pronounce death as long as the following circumstances are met: 1) the PA works in home health, hospice, a hospital, a nursing home, a state-operated hospital, or the Department of Corrections, 2) the PA is directly involved in the care of the patient, 3) death has occurred, 4) the patient is under the care of a physician when death occurs, 5) death is anticipated, 6) the physician is unable to be present within a reasonable time, and 7) there is a valid DNR order. The PA must inform the physician as soon as practicable and inform the chief medical examiner if the death was unexpected.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0092

SB 573
This legislation provides for an extension to a professional license of one year after an individual's release from active military duty.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP1017

NEW REGULATIONS NOW IN EFFECT

§18 VAC 85-20-10 et seq All Professions
The board must perform a periodic review of its regulations every two years. Changes are usually of a minor,

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cleanup nature. The reviewed and revised regulations took effect Feb. 25, 2004.

§18 VAC 85-20-22 Medicine, Osteopathic Medicine, Podiatry & Chiropractic
These regulations, effective July 14, 2004, replace emergency regulations from 2003 that raised fees pursuant to HB 1441 from the 2003 Session of the General Assembly. The renewal fee for doctors of medicine, osteopathic medicine and podiatry is now $337 and for doctors of chiropractic is $312.

§18 VAC 85-110 Licensed Acupuncture
In effect April 26, 2004, these regulations allow licensure of a graduate from a school of acupuncture who graduated while the school was in candidacy status for accreditation, as long as the school achieves accreditation from the Accreditation Commission on Acupuncture and Oriental Medicine within three years of the applicant's graduation.

18 VAC 85-80-61 Occupational Therapy
Pursuant to HB 309, the board designated the National Board of Certification in Occupational Therapy designation as an occupational therapy assistant as the credential necessary for an individual to hold himself out or advertise as an occupational therapy assistant, or use the OTA designation. These emergency regulations took effect July 27, 2004.

18 VAC 85-120-75 Athletic Training
Athletic trainers who are seeking licensure in Virginia may be allowed up to 45 days of practice prior to final licensure provided most of the documentation necessary for licensure has been submitted. As some documents take a number of weeks to obtain, athletic trainers will be able to commit to a new position in Virginia without losing it due to a delay in getting documents in to the board. These regulations went into effect Sept. 8, 2004.

18 VAC 85-120-10 et seq Athletic Training
The regulations have been changed to reflect the law that athletic trainers are now licensed, instead of certified. These became effective Aug. 25, 2004.

§18 VAC 85-15-10 et seq All Professions
In response to HB 577, these regulations define an agency subordinate as a single member of the board, board staff, or another individual deemed qualified for the fact-finding task. The regulations limit the types of cases that may be heard by an agency subordinate to profiling, continuing education, advertising, defaults on student loans, failure to provide medical records and compliance with previous orders of the board. These regulations went into effect on Aug. 31, 2004.

§18 VAC 90-30-120 Nurse Practitioners
HB 855 expanded the authority of nurse practitioners to sign numerous forms that previously required the signature of a physician. These emergency regulations specify that the written protocol between the doctor and the nurse practitioner shall include the nurse practitioner's authority for signatures, certifications, stamps, verifications and endorsements in keeping with the specialty license of the nurse practitioner and the scope of practice of the supervising physician. These regulations went into effect on Sept. 8, 2004.

§18 VAC 90-30-80 et seq Nurse Practitioners
HB 633 concerns the Nurse Licensure Compact that allows nurses to move between participating compact states without obtaining new licensure. The regulations clarify that a nurse practitioner must hold a license as a registered nurse in Virginia or in a compact state to obtain a license as a nurse practitioner. These regulations went into effect Sept. 8, 2004.

PROPOSED REGULATIONS

18 VAC 85-20-10 et seq All Professions
In June 2003, the board set in motion the process for establishing standards of professional conduct for all its professions. The board made the determination that it would review the ethical standards documents for the various professions and derive its own set of regulations, rather than adopt the entirety of the documents of any profession. The results of this effort are that the board approved these proposed regulations on June 24, 2004. They are currently under Executive Branch review prior to publication for public comment.

18 VAC 90-30-10 Nurse Practitioners
These regulations governing nurse practitioners clarify that a graduate degree in nursing will henceforth be required for licensure as a nurse practitioner and that an applicant must submit evidence of professional certification consistent with the specialty area of the applicant's educational preparation by an agency accepted by the boards of Nursing and Medicine. The regulations were approved as proposed regulations by the board on April

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22, 2004. They are currently in the public comment period.

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WEST VIRGINIA

HOSPITAL PREPAREDNESS IN WEST VIRGINIA

As the nation prepares for future disasters, particularly bioterrorism events, following 9/11, the West Virginia Bureau for Public Health Division of Threat Preparedness, in conjunction with the West Virginia Office of Emergency Services and the West Virginia Hospital Association, has been working to help hospitals in the state prepare for the worst. The current goal is to prepare for a surge capacity of at least 500 ill or injured patients per million population needing hospitalization as the result of a weapons of mass destruction (WMD) event, flu pandemic or other major disaster. A variety of activities are underway.

With the assistance of federal grant money from the Health Resources and Services Administration (HRSA), West Virginia hospitals are buying chemically resistant decontamination supplies, additional N95 masks, chemical and nerve agent antidotes, computers for Internet connection to the Centers for Disease Control and Prevention (CDC) and state Bureau for Public Health websites, radios and pagers for hospital security/safety personnel, etc. After committing to a three-tiered level of preparedness, the hospitals are being issued shelters and equipment for large-scale decontamination, along with training in their use.

This past year, the development of regional plans to deal with large-scale events has been a top priority. This year, training for hospital personnel will be addressed through ongoing courses in threat awareness and decontamination.

One of the biggest areas of focus will be enhancing isolation capacity so that all hospitals will be able to have either fixed or portable negative pressure isolation areas to care for patients with highly infectious diseases. The goal is for every hospital to be capable of caring for at least one highly infectious patient, and at least one hospital in each of the state's seven regions to be capable of caring for 10 or more such patients. Attention to the capabilities of hospital labs and their ability to process a potentially dangerous agent is also an area of focus.

Disease surveillance using manual reporting has been an ongoing problem, since the data often lags several days behind the patient's presentation and is sometimes incomplete.

For more timely identification and tracking of infectious diseases, the West Virginia Electronic Disease Surveillance System (WVEDSS) is being established. This will electronically connect providers and labs with the Bureau for Public Health to allow automated disease reporting.

Finally, and perhaps most challenging of all, will be the recruitment and advance credentialing of medical personnel who will volunteer to help in such a crisis. For more information, contact William D. Rose, M.D., FACEP, at wrose66@adelphia.net.

WHY DO CONSUMERS FILE COMPLAINTS AGAINST PHYSICIANS?

The most common complaint consumers have is not about fees or quality of care, but is related to the conduct of a physician – lack of attention or disinterest on the part of the physician (or even the staff), rudeness or failure to provide medical records when requested. When a beloved relative dies, apparent lack of sensitivity and communication issues often result in complaints. These are all areas where a physician's efforts to improve may result in fewer complaints being filed and less headaches for physicians.

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LET US HEAR FROM YOU

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